

A NONSUBSTANTIVE REVISION
OF STATUTES RELATING TO
INSURANCE FEES AND TAXES, CONSUMER INTERESTS,
HEALTH INSURANCE AND RELATED PRODUCTS, TITLE INSURANCE,
AND INSURANCE INDUSTRY PROFESSIONALS

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1 (f) Claim information provided by an employer
2 carrier under this section shall be provided in the
3 aggregate, without information through which a
4 specific individual covered by the health insurance or
5 evidence of coverage may be identified.

6 Revised Law

7 Sec. 1501.615. ADDITIONAL REPORTING REQUIREMENTS. The
8 department may require periodic reports by large employer health
9 benefit plan issuers and agents regarding the large employer health
10 benefit plans issued by those issuers. The reporting requirements
11 must:

12 (1) require information regarding the number of plans
13 in various categories that are marketed or issued to large
14 employers; and

15 (2) comply with federal law, including regulations.
16 (V.T.I.C. Art. 26.91, Subsec. (b).)

17 Source Law

18 (b) The department may require periodic reports
19 by large employer carriers and agents regarding the
20 large employer health benefit plans issued by those
21 carriers. The reporting requirements must require
22 information regarding the number of large employer
23 health benefit plans in various categories that are
24 marketed or issued to large employers and must comply
25 with federal law and regulations.

26 Revised Law

27 Sec. 1501.616. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR.
28 If a large employer health benefit plan issuer enters into an
29 agreement with a third-party administrator to provide
30 administrative, marketing, or other services related to offering
31 large employer health benefit plans to large employers in this
32 state, the third-party administrator is subject to this subchapter
33 and Subchapter C. (V.T.I.C. Art. 26.95.)

34 Source Law

35 Art. 26.95. If a large employer carrier enters
36 into an agreement with a third-party administrator to
37 provide administrative, marketing, or other services
38 related to the offering of large employer health
39 benefit plans to large employers in this state, the
40 third-party administrator is subject to this
41 subchapter.

42 CHAPTER 1502. HEALTH BENEFIT PLANS FOR CHILDREN

43 SUBCHAPTER A. GENERAL PROVISIONS

1 Sec. 1502.001. APPLICABILITY OF CHAPTER 1271

2 Sec. 1502.002. RULES 1273

3 [Sections 1502.003-1502.050 reserved for expansion]

4 SUBCHAPTER B. CHILDREN'S HEALTH BENEFIT PLAN

5 Sec. 1502.051. CHILDREN'S HEALTH BENEFIT PLAN 1274

6 Sec. 1502.052. MANDATED BENEFIT PROVISIONS INAPPLICABLE. . . 1274

7 Sec. 1502.053. EXEMPTION FROM CERTAIN TAXES 1274

8 CHAPTER 1502. HEALTH BENEFIT PLANS FOR CHILDREN

9 SUBCHAPTER A. GENERAL PROVISIONS

10 Revised Law

11 Sec. 1502.001. APPLICABILITY OF CHAPTER. This chapter

12 applies only to the issuer of a health benefit plan that:

13 (1) provides benefits for medical or surgical expenses

14 incurred as a result of a health condition, accident, or sickness,

15 including:

16 (A) an individual, group, blanket, or franchise

17 insurance policy or insurance agreement, a group hospital service

18 contract, or an individual or group evidence of coverage that is

19 offered by:

- 20 (i) an insurance company;
- 21 (ii) a group hospital service corporation
- 22 operating under Chapter 842;
- 23 (iii) a fraternal benefit society operating
- 24 under Chapter 885;
- 25 (iv) a stipulated premium company operating
- 26 under Chapter 884; or
- 27 (v) a health maintenance organization
- 28 operating under Chapter 843; and

29 (B) to the extent permitted by the Employee

30 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et

31 seq.), a health benefit plan that is offered by:

32 (i) a multiple employer welfare arrangement

33 as defined by Section 3 of that Act or another analogous benefit

34 arrangement; or

1 (ii) an entity not authorized under this
2 code or another insurance law of this state that contracts directly
3 for health care services on a risk-sharing basis, including a
4 capitation basis; or

5 (2) is offered by an approved nonprofit health
6 corporation that holds a certificate of authority under Chapter
7 844. (V.T.I.C. Art. 27.02.)

8 Source Law

9 Art. 27.02. This chapter applies to a health
10 benefit plan that:

11 (1) provides benefits for medical or
12 surgical expenses incurred as a result of a health
13 condition, accident, or sickness, including:

14 (A) an individual, group, blanket, or
15 franchise insurance policy or insurance agreement, a
16 group hospital service contract, or an individual or
17 group evidence of coverage that is offered by:

18 (i) an insurance company;
19 (ii) a group hospital service
20 corporation operating under Chapter 20 of this code;

21 (iii) a fraternal benefit
22 society operating under Chapter 10 of this code;

23 (iv) a stipulated premium
24 insurance company operating under Chapter 22 of this
25 code; or

26 (v) a health maintenance
27 organization operating under the Texas Health
28 Maintenance Organization Act (Chapter 20A, Vernon's
29 Texas Insurance Code); or

30 (B) to the extent permitted by the
31 Employee Retirement Income Security Act of 1974 (29
32 U.S.C. Section 1001 et seq.), a health benefit plan
33 that is offered by:

34 (i) a multiple employer welfare
35 arrangement as defined by Section 3, Employee
36 Retirement Income Security Act of 1974 (29 U.S.C.
37 Section 1002) or another analogous benefit
38 arrangement; or

39 (ii) any other entity not
40 licensed under this code or another insurance law of
41 this state that contracts directly for health care
42 services on a risk sharing basis, including an entity
43 that contracts for health care services on a
44 capitation basis; or

45 (2) is offered by an approved nonprofit
46 health corporation that is certified under Section
47 5.01(a), Medical Practice Act (Article 4495b, Vernon's
48 Texas Civil Statutes), and that holds a certificate of
49 authority issued by the commissioner under Article
50 21.52F of this code.

51 Revisor's Note

52 (1) V.T.I.C. Article 27.02(1)(B)(ii) refers to
53 a health benefit plan offered by an entity that is not
54 "licensed" under the Insurance Code or another

1 insurance law of this state. The revised law
2 substitutes "authorized" for "licensed" for
3 consistency with terminology used throughout this
4 code.

5 (2) V.T.I.C. Article 27.02(2) refers to an
6 approved nonprofit health corporation that is
7 "certified under Section 5.01(a), Medical Practice
8 Act," and holds a certificate of authority "issued by
9 the commissioner under Article 21.52F." The revised
10 law omits the reference to certification under Section
11 5.01(a), Medical Practice Act (Article 4495b, Vernon's
12 Texas Civil Statutes), which was codified in 1999 in
13 Chapter 162, Occupations Code, as unnecessary because
14 V.T.I.C. Article 21.52F, revised as Chapter 844 of
15 this code, requires a nonprofit corporation to be
16 certified under that provision as a condition of
17 holding a certificate of authority. The revised law
18 also omits the reference to the commissioner issuing
19 the certificate of authority as unnecessary because
20 Chapter 844 requires the commissioner to issue the
21 certificate of authority.

22 (3) V.T.I.C. Article 27.01 defines "health
23 benefit plan." The revised law omits the definition as
24 unnecessary because V.T.I.C. Article 27.02, revised as
25 Section 1502.001, specifies the types of health
26 benefit plans that may be issued by a health benefit
27 plan issuer to which the chapter applies, and thus the
28 defined term is not helpful to the reader. The omitted
29 law reads:

30 Art. 27.01. In this chapter, "health
31 benefit plan" means a health benefit plan
32 described by Article 27.02 of this code.

33 Revised Law

34 Sec. 1502.002. RULES. The commissioner may adopt rules to
35 implement this chapter. (V.T.I.C. Art. 27.06.)

benefit plan is not subject to the premium tax imposed by Article 4.11 of this code or the tax on revenues imposed under Section 33, Texas Health Maintenance Organization Act (Article 20A.33, Vernon's Texas Insurance Code), with respect to money received for coverage provided under that plan.

CHAPTER 1503. COVERAGE OF CERTAIN STUDENTS

Sec. 1503.001. APPLICABILITY OF CHAPTER 1275

Sec. 1503.002. EXCEPTION. 1277

Sec. 1503.003. COVERAGE OF CERTAIN STUDENTS 1278

CHAPTER 1503. COVERAGE OF CERTAIN STUDENTS

Revised Law

Sec. 1503.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

- (i) an insurance company;
- (ii) a group hospital service corporation operating under Chapter 842;
- (iii) a fraternal benefit society operating under Chapter 885;
- (iv) a stipulated premium company operating under Chapter 884; or
- (v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

- (i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or
- (ii) an analogous benefit arrangement; or

(2) is offered by:

1 (A) an approved nonprofit health corporation
2 that holds a certificate of authority under Chapter 844; or

3 (B) another entity that:

4 (i) is not authorized under this code or
5 another insurance law of this state; and

6 (ii) contracts directly for health care
7 services on a risk-sharing basis, including a capitation basis.

8 (V.T.I.C. Art. 21.24-2, Sec. 2(a).)

9 Source Law

10 [Sec. 1. In this article, "health benefit plan"
11 means a plan described by Section 2 of this article.]

12 Sec. 2. (a) This article applies to a health
13 benefit plan that:

14 (1) provides benefits for medical or
15 surgical expenses incurred as a result of a health
16 condition, accident, or sickness, including:

17 (A) an individual, group, blanket, or
18 franchise insurance policy or insurance agreement, a
19 group hospital service contract, or an individual or
20 group evidence of coverage that is offered by:

21 (i) an insurance company;

22 (ii) a group hospital service
23 corporation operating under Chapter 20 of this code;

24 (iii) a fraternal benefit
25 society operating under Chapter 10 of this code;

26 (iv) a stipulated premium
27 insurance company operating under Chapter 22 of this
28 code; or

29 (v) a health maintenance
30 organization operating under the Texas Health
31 Maintenance Organization Act (Chapter 20A, Vernon's
32 Texas Insurance Code); or

33 (B) to the extent permitted by the
34 Employee Retirement Income Security Act of 1974 (29
35 U.S.C. Section 1001 et seq.), a health benefit plan
36 that is offered by:

37 (i) a multiple employer welfare
38 arrangement as defined by Section 3, Employee
39 Retirement Income Security Act of 1974 (29 U.S.C.
40 Section 1002); or

41 (ii) another analogous benefit
42 arrangement;

43 (2) is offered by an approved nonprofit
44 health corporation that is certified under Section
45 162.001, Occupations Code, and that holds a
46 certificate of authority issued by the commissioner
47 under Article 21.52F of this code; or

48 (3) is offered by any other entity not
49 licensed under this code or another insurance law of
50 this state that contracts directly for health care
51 services on a risk-sharing basis, including an entity
52 that contracts for health care services on a
53 capitation basis.

54 Revisor's Note

55 (1) Section 2(a)(2), V.T.I.C. Article 21.24-2,

1 refers to an approved nonprofit health corporation
2 that is "certified under Section 162.001, Occupations
3 Code," and holds a certificate of authority "issued by
4 the commissioner under Article 21.52F." The revised
5 law omits the reference to certification under Section
6 162.001, Occupations Code, as unnecessary because
7 V.T.I.C. Article 21.52F, revised as Chapter 844 of
8 this code, requires a nonprofit corporation to be
9 certified under Section 162.001, Occupations Code, as
10 a condition of holding a certificate of authority. The
11 revised law also omits as unnecessary the reference to
12 the commissioner's issuing the certificate of
13 authority because Chapter 844 requires the
14 commissioner to issue the certificate of authority.

15 (2) Section 2(a)(3), V.T.I.C. Article 21.24-2,
16 refers to a health benefit plan offered by an entity
17 not "licensed" under this code or another insurance
18 law of this state. The revised law substitutes
19 "authorized" for "licensed" for consistency with
20 terminology used throughout this code.

21 Revised Law

22 Sec. 1503.002. EXCEPTION. This chapter does not apply to:

23 (1) a plan that provides coverage:

24 (A) only for a specified disease;

25 (B) only for accidental death or dismemberment;

26 (C) for wages or payments in lieu of wages for a
27 period during which an employee is absent from work because of
28 sickness or injury; or

29 (D) as a supplement to a liability insurance
30 policy;

31 (2) a small employer health benefit plan written under
32 Chapter 1501;

33 (3) a Medicare supplemental policy as defined by
34 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),

1 as amended;

2 (4) a workers' compensation insurance policy;

3 (5) medical payment insurance coverage provided under
4 a motor vehicle insurance policy; or

5 (6) a long-term care insurance policy, including a
6 nursing home fixed indemnity policy, unless the commissioner
7 determines that the policy provides benefit coverage so
8 comprehensive that the policy is a health benefit plan as described
9 by Section 1503.001. (V.T.I.C. Art. 21.24-2, Sec. 2(b).)

10 Source Law

11 [Sec. 1. In this article, "health benefit plan"
12 means a plan described by Section 2 of this article.]

13 [Sec. 2]

14 (b) This article does not apply to:

15 (1) a plan that provides coverage:

16 (A) only for a specified disease;

17 (B) only for accidental death or
18 dismemberment;

19 (C) for wages or payments in lieu of
20 wages for a period during which an employee is absent
21 from work because of sickness or injury; or

22 (D) as a supplement to liability
23 insurance;

24 (2) a small employer health benefit plan
25 written under Chapter 26 of this code;

26 (3) a Medicare supplemental policy as
27 defined by Section 1882(g)(1), Social Security Act (42
28 U.S.C. Section 1395ss);

29 (4) workers' compensation insurance
30 coverage;

31 (5) medical payment insurance issued as
32 part of a motor vehicle insurance policy; or

33 (6) a long-term care policy, including a
34 nursing home fixed indemnity policy, unless the
35 commissioner determines that the policy provides
36 benefit coverage so comprehensive that the policy is a
37 health benefit plan as described by Subsection (a) of
38 this section.

39 Revised Law

40 Sec. 1503.003. COVERAGE OF CERTAIN STUDENTS. (a) A
41 health benefit plan may not condition coverage for a child younger
42 than 25 years of age on the child's being enrolled at an educational
43 institution.

44 (b) A health benefit plan that requires as a condition of
45 coverage for a child up to 25 years of age that the child be a
46 full-time student at an educational institution must provide the
47 coverage:

1 (1) for the entire academic term during which the
2 child begins as a full-time student and remains enrolled,
3 regardless of whether the number of hours of instruction for which
4 the child is enrolled is reduced to a level that changes the child's
5 academic status to less than that of a full-time student; and

6 (2) continuously until the 10th day of instruction of
7 the subsequent academic term, on which date the health benefit plan
8 may terminate coverage for the child if the child does not return to
9 full-time student status before that date.

10 (c) For purposes of this section, determination of the
11 full-time student status of a child is made in the manner provided
12 by the educational institution at which the child is enrolled.
13 (V.T.I.C. Art. 21.24-2, Sec. 3.)

14 Source Law

15 Sec. 3. (a) Each health benefit plan that
16 conditions coverage for a child up to 25 years of age
17 on the child's being a full-time student at an
18 educational institution shall provide the coverage for
19 an entire academic term during which the child begins
20 as a full-time student and remains enrolled,
21 regardless of whether the number of hours of
22 instruction for which the child is enrolled is reduced
23 to a level that changes the child's academic status to
24 less than that of a full-time student. Additionally,
25 the health benefit plan shall provide the coverage
26 continuously until the 10th day of instruction of the
27 subsequent academic term on which date the health
28 benefit plan may terminate coverage of the child if the
29 child does not return to full-time student status
30 before that date. A health benefit plan may not
31 condition coverage for a child younger than 25 years of
32 age on the child's being enrolled at an educational
33 institution.

34 (b) For purposes of this section, determination
35 of the full-time student status of a child subject to
36 this article is made in the manner provided by the
37 educational institution at which the child is
38 enrolled.

39 Revisor's Note
40 (End of Chapter)

41 Section 1, V.T.I.C. Article 21.24-2, defines
42 "health benefit plan." The revised law omits the
43 definition as unnecessary because Section 2 of that
44 article, revised as Sections 1503.001 and 1503.002,
45 specifies the types of health benefit plans to which
46 this chapter applies, and thus the defined term is not

helpful to the reader. The omitted law reads:

Art. 21.24-2

Sec. 1. In this article, "health benefit plan" means a plan described by Section 2 of this article.

CHAPTER 1504. MEDICAL CHILD SUPPORT

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1504.001. DEFINITIONS 1280

Sec. 1504.002. RULES 1282

Sec. 1504.003. VIOLATION OF CHAPTER: RELIEF AVAILABLE
TO INJURED PERSON 1283

[Sections 1504.004-1504.050 reserved for expansion]

SUBCHAPTER B. DUTIES OF HEALTH BENEFIT PLAN ISSUER

Sec. 1504.051. ENROLLMENT OF CERTAIN CHILDREN REQUIRED . . . 1284

Sec. 1504.052. CHILD RESIDING OUTSIDE SERVICE AREA;
COMPARABLE HEALTH COVERAGE REQUIRED 1284

Sec. 1504.053. CANCELLATION OR NONRENEWAL OF COVERAGE
FOR CERTAIN CHILDREN 1286

Sec. 1504.054. CONTINUATION OR CONVERSION OF COVERAGE 1286

Sec. 1504.055. PROCEDURE FOR CLAIMS 1287

[Sections 1504.056-1504.100 reserved for expansion]

SUBCHAPTER C. PROHIBITED CONDUCT

Sec. 1504.101. DENIAL OF ENROLLMENT ON CERTAIN GROUNDS
PROHIBITED 1289

Sec. 1504.102. ASSIGNMENT OF MEDICAL SUPPORT RIGHTS:
DIFFERENT REQUIREMENTS PROHIBITED 1290

CHAPTER 1504. MEDICAL CHILD SUPPORT

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1504.001. DEFINITIONS. In this chapter:

- (1) "Child" has the meaning assigned by Section 101.003, Family Code.
- (2) "Child support agency" has the meaning assigned by Section 101.004, Family Code.
- (3) "Custodial parent" means an individual who:

1 (A) is a managing conservator of a child or a
2 possessory conservator of a child who is a parent of the child; or

3 (B) is a guardian of the person or other
4 custodian of a child and is designated as guardian or custodian by a
5 court or administrative agency of this or another state.

6 (4) "Health benefit plan issuer" means:

7 (A) an insurance company, group hospital service
8 corporation, or health maintenance organization that delivers or
9 issues for delivery an individual, group, blanket, or franchise
10 insurance policy or agreement, a group hospital service contract,
11 or an evidence of coverage that provides benefits for medical or
12 surgical expenses incurred as a result of an accident or sickness;

13 (B) a governmental entity subject to Subchapter
14 D, Chapter 1355, Subchapter C, Chapter 1364, Chapter 1578, or
15 Article 3.51-1, 3.51-2, 3.51-4, or 3.51-5;

16 (C) the issuer of a multiple employer welfare
17 arrangement as defined by Section 846.001; or

18 (D) the issuer of a group health plan as defined
19 by Section 607, Employee Retirement Income Security Act of 1974 (29
20 U.S.C. Section 1167).

21 (5) "Medical assistance" means medical assistance
22 under the state Medicaid program. (V.T.I.C. Art. 3.96-1.)

23 Source Law

24 Art. 3.96-1. In this subchapter:

25 (1) "Child" has the meaning assigned by
26 Subsections (a) and (b), Section 101.003, Family Code.

27 (2) "Child support agency" has the meaning
28 assigned by Section 101.004, Family Code.

29 (3) "Custodial parent" means:

30 (A) a managing conservator of a child
31 or a possessory conservator of a child who is a parent
32 of the child; or

33 (B) a guardian of the person of a
34 child, or another custodian of a child if the guardian
35 or custodian is designated by a court or
36 administrative agency of this or another state.

37 (4) "Health insurer" means any insurance
38 company, group hospital service corporation, or health
39 maintenance organization that delivers or issues for
40 delivery an individual, group, blanket, or franchise
41 insurance policy or insurance agreement, a group
42 hospital service contract, or an evidence of coverage
43 that provides benefits for medical or surgical
44 expenses incurred as a result of an accident or

sickness.

(5) "Insurer" means:

(A) a health insurer;

(B) a governmental entity subject to:

(i) Article 3.51-1, 3.51-2, 3.51-4, 3.51-5, or 3.51-5A of this code; or

(ii) Section 1, Chapter 123, Acts of the 60th Legislature, Regular Session, 1967 (Article 3.51-3, Vernon's Texas Insurance Code);

(C) a multiple employer welfare arrangement, as that term is defined by Article 3.95-1 of this code; or

(D) a group health plan, as defined by Section 607(1), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1167).

(6) "Medical assistance" means medical assistance under the state Medicaid program.

Revisor's Note

Subdivision (5), V.T.I.C. Article 3.96-1, defines "insurer" to include the defined term "health insurer." "Health insurer" is a term used in conjunction with traditional health insurance. Included in the definition of "health insurer" are entities such as health maintenance organizations, which are not traditional insurers. Consequently, "health benefit plan issuer" is a more accurate term than "insurer," and throughout this chapter, the revised law substitutes "health benefit plan issuer" for "insurer." In addition, because the term "health insurer" is only used in the definition of "insurer," the revised law omits the definition of "health insurer" and includes the substance of the definition in the definition of "health benefit plan issuer." Comparable changes necessary to ensure consistent terminology have been made throughout the chapter.

Revised Law

Sec. 1504.002. RULES. (a) The commissioner shall adopt reasonable rules as necessary to implement this chapter and 42 U.S.C. Section 1396a(a)(60), including rules that define acts that constitute unfair or deceptive practices under Subchapter I, Chapter 541.

(b) The commissioner shall adopt rules that define

1 "comparable health coverage" in a manner that:

2 (1) is consistent with federal law; and

3 (2) complies with the requirements necessary to
4 maintain federal Medicaid funding. (V.T.I.C. Art. 3.96-8, Sec.
5 (c); Art. 3.96-10.)

6 Source Law

7 [Art. 3.96-8]

8 (c) The commissioner shall adopt rules to define
9 "comparable coverage" in a manner consistent with
10 federal law and that meet requirements to maintain
11 federal Medicaid funding.

12 Art. 3.96-10. The commissioner shall adopt
13 reasonable rules as necessary to implement this
14 subchapter and the requirements of 42 U.S.C. Section
15 1396a(a)(60), including rules defining acts that
16 constitute unfair or deceptive practices under Section
17 13, Article 21.21, of this code.

18 Revisor's Note

19 Section (c), V.T.I.C. Article 3.96-8, requires
20 the commissioner of insurance to adopt rules defining
21 "comparable coverage" in a manner that is consistent
22 with federal law. For consistency of terms between
23 state and federal laws, the revised law substitutes
24 "comparable health coverage" for "comparable
25 coverage" because that is the term used in 42 U.S.C.
26 Section 1396g-1 (providing a list of the
27 state-required medical child support laws).
28 Appropriate changes have been made throughout this
29 chapter.

30 Revised Law

31 Sec. 1504.003. VIOLATION OF CHAPTER: RELIEF AVAILABLE TO
32 INJURED PERSON. A health benefit plan issuer that violates this
33 chapter is subject to the same penalties, and an injured person has
34 the same rights and remedies, as those provided by Subchapter D,
35 Chapter 541. (V.T.I.C. Art. 3.96-9.)

36 Source Law

37 Art. 3.96-9. An insurer that violates this
38 subchapter is subject to the same penalties, and an
39 injured party has the same rights and remedies, as
40 those provided by Section 16, Article 21.21, of this

code.

[Sections 1504.004-1504.050 reserved for expansion]

SUBCHAPTER B. DUTIES OF HEALTH BENEFIT PLAN ISSUER

Revised Law

Sec. 1504.051. ENROLLMENT OF CERTAIN CHILDREN
REQUIRED. (a) A health benefit plan issuer shall permit a parent
to enroll a child in dependent health coverage offered through the
issuer regardless of any enrollment period restriction if the
parent is:

(1) eligible for dependent health coverage; and

(2) required by a court order or administrative order
to provide health insurance coverage for the child.

(b) A health benefit plan issuer shall enroll a child of a
parent described by Subsection (a) in dependent health coverage
offered through the issuer if:

(1) the parent does not apply to obtain health
coverage for the child through the issuer; and

(2) the child, a custodial parent of the child, or a
child support agency having a duty to collect or enforce support for
the child applies for the coverage. (V.T.I.C. Art. 3.96-3.)

Source Law

Art. 3.96-3. (a) If a parent eligible for
dependent health coverage through an insurer is
required by a court or administrative order to provide
health coverage for a child, the insurer shall permit
the parent to enroll the child without regard to any
enrollment period restriction.

(b) If a parent eligible for dependent health
coverage through an insurer is required by a court or
administrative order to provide health coverage for a
child and fails to apply to obtain the health insurance
coverage for the child, the insurer shall enroll the
child on application of a custodial parent of the
child, a child support agency having a duty to collect
or enforce support for the child, or the child.

Revised Law

Sec. 1504.052. CHILD RESIDING OUTSIDE SERVICE AREA;
COMPARABLE HEALTH COVERAGE REQUIRED. (a) A health benefit plan
issuer may not deny enrollment of a child under the health coverage
of the child's parent on the ground that the child does not reside
in the issuer's service area.

1 (b) A health benefit plan issuer may not enforce an
2 otherwise applicable provision of the health coverage that would
3 deny, limit, or reduce payment of a claim for a covered child who
4 resides outside the issuer's service area but inside the United
5 States.

6 (c) For a covered child who resides outside the health
7 benefit plan issuer's service area and whose coverage under a
8 policy or plan is required by a medical support order, the issuer
9 shall provide coverage that is comparable health coverage to that
10 provided to other dependents under the policy or plan.

11 (d) Comparable health coverage may include coverage in
12 which a health benefit plan issuer uses different procedures for
13 service delivery and health care provider reimbursement.
14 Comparable health coverage may not include coverage:

15 (1) that is limited to emergency services only; or

16 (2) for which the issuer charges a higher premium.

17 (V.T.I.C. Art. 3.96-2 (part); Art. 3.96-8, Secs. (a), (b).)

18 Source Law

19 Art. 3.96-2. An insurer may not deny enrollment
20 of a child under the health insurance coverage of the
21 child's parent on the ground that the child:

22 . . .
23 (4) does not reside . . . in the insurer's
24 service area; or

25 Art. 3.96-8. (a) An insurer shall provide
26 coverage for a covered child who resides outside the
27 insurer's service area, and whose coverage under a
28 policy or plan is required by a medical support order,
29 that is comparable coverage to that provided to other
30 dependents under the policy or plan. In this
31 subsection, "comparable coverage" may include
32 coverage under which an insurer uses different
33 procedures for service delivery and health care
34 provider reimbursement. The coverage may not be
35 limited to emergency services only. The coverage may
36 not include coverage for which the insurer charges a
37 higher premium.

38 (b) An insurer may not enforce otherwise
39 applicable provisions that would deny, limit, or
40 reduce payment for claims for a covered child who lives
41 outside the insurer's coverage territory but inside
42 the United States.

43 Revisor's Note

44 Section (b), V.T.I.C. Article 3.96-8, refers to a
45 health benefit plan issuer's "coverage territory."

The revised law substitutes "service area" for "coverage territory" for consistency of terms in this chapter.

Revised Law

Sec. 1504.053. CANCELLATION OR NONRENEWAL OF COVERAGE FOR CERTAIN CHILDREN. (a) A health benefit plan issuer may not cancel or refuse to renew health coverage provided to a child who is enrolled or entitled to enrollment under this chapter unless satisfactory written evidence is filed with the issuer showing that:

(1) the court or administrative order that required the coverage is not in effect; or

(2) the child:

(A) is enrolled in comparable health coverage; or

(B) will be enrolled in comparable health coverage that takes effect not later than the effective date of the cancellation or nonrenewal.

(b) For purposes of this section, a child is not enrolled or entitled to enrollment under this chapter if the child's eligibility for health coverage ends because the parent ceases to be eligible for dependent health coverage. (V.T.I.C. Art. 3.96-4.)

Source Law

Art. 3.96-4. (a) An insurer may not cancel or refuse to renew insurance coverage of a child entitled to enrollment or enrolled under this subchapter unless satisfactory written evidence is filed with the insurer that shows that:

(1) the court order or administrative order that required the coverage is no longer in effect; or

(2) the child is enrolled in comparable health insurance coverage or will be enrolled in comparable coverage that will take effect not later than the effective date of the cancellation or nonrenewal.

(b) As used in this section, "a child entitled to enrollment or enrolled under this subchapter" does not include a child whose eligibility has terminated because the parent eligible for dependent health coverage is no longer eligible for such coverage.

Revised Law

Sec. 1504.054. CONTINUATION OR CONVERSION OF COVERAGE. (a)

1 If a child's eligibility for dependent health coverage ends because
2 the parent ceases to be eligible for the coverage and the coverage
3 provides for the continuation or conversion of the coverage for the
4 child, the health benefit plan issuer shall notify the custodial
5 parent and the child support agency of the costs and other
6 requirements for continuing or converting the coverage.

7 (b) The health benefit plan issuer shall, on application of
8 a parent of the child, a child support agency, or the child, enroll
9 or continue enrollment of a child whose eligibility for coverage
10 ended under Subsection (a). (V.T.I.C. Art. 3.96-5.)

11 Source Law

12 Art. 3.96-5. If dependent health coverage being
13 terminated pursuant to Subsection (b), Article 3.96-4,
14 of this code contains provisions for the continuation
15 or conversion of such coverage for the child, the
16 insurer shall notify the custodial parent and the
17 child support agency of the costs and other
18 requirements for extending or converting such
19 coverage, and shall enroll or continue enrollment of
20 the child on application of a parent of the child, a
21 child support agency, or the child.

22 Revisor's Note

23 V.T.I.C. Article 3.96-5 refers to requirements
24 for "extending or converting" health insurance
25 coverage. The revised law substitutes "continuing"
26 for "extending" for consistency of terms in this
27 section.

28 Revised Law

29 Sec. 1504.055. PROCEDURE FOR CLAIMS. (a) A health benefit
30 plan issuer that provides health coverage to a child through a
31 covered parent of the child shall:

32 (1) provide to each custodial parent of the child or to
33 an adult child documents and other information necessary for the
34 child to obtain benefits under the coverage, including:

- 35 (A) the name of the issuer;
- 36 (B) the number of the policy or evidence of
37 coverage;
- 38 (C) a copy of the policy or evidence of coverage

1 and schedule of benefits;

2 (D) a health coverage membership card;

3 (E) claim forms; and

4 (F) any other document or information necessary
5 to submit a claim in accordance with the issuer's policies and
6 procedures;

7 (2) permit a custodial parent, health care provider,
8 state agency that has been assigned medical support rights, or
9 adult child to submit claims for covered services without the
10 approval of the covered parent; and

11 (3) make payments on covered claims submitted in
12 accordance with this subsection directly to a custodial parent,
13 health care provider, adult child, or state agency making a claim.

14 (b) A health benefit plan issuer shall provide to a state
15 agency that provides medical assistance to the child or shall
16 provide to a child support agency that enforces medical support on
17 behalf of a child the information necessary to obtain reimbursement
18 of medical services provided to or paid on behalf of the child.
19 (V.T.I.C. Art. 3.96-6, Sec. (b); Art. 3.96-7.)

20 Source Law

21 [Art. 3.96-6]

22 (b) An insurer shall provide to a state agency
23 providing medical assistance, or to a child support
24 agency enforcing medical support, information as
25 necessary to facilitate reimbursement of medical
26 services provided to or paid on behalf of a child.

27 Art. 3.96-7. (a) If a child receives health
28 insurance coverage through the insurer of a parent of
29 the child, that insurer must provide information and
30 documents to each custodial parent or an adult child as
31 necessary for the child to obtain benefits through
32 that coverage, including:

33 (1) the name of the insurer;

34 (2) the number of the policy;

35 (3) a copy of the policy and schedule of
36 benefits;

37 (4) a health insurance membership card;

38 (5) claim forms; and

39 (6) any other information or document
40 necessary to submit a claim in accordance with the
41 insurer's policies and procedures.

42 (b) The insurer shall permit a custodial parent,
43 a health care provider, adult child, or a state agency
44 that has been assigned medical support rights to
45 submit claims for covered services without the
46 approval of the insured parent.

47 (c) The insurer shall make payments on covered

1 claims submitted in accordance with this article
2 directly to the custodial parent, health care
3 provider, adult child, or state agency making the
4 claim.

5 Revisor's Note

6 (1) Sections (a)(2) and (3), V.T.I.C. Article
7 3.96-7, refer to a "policy" in the context of providing
8 health coverage by a health benefit plan issuer. In
9 this chapter, "health benefit plan issuer" is defined
10 to include entities such as health maintenance
11 organizations. These entities generally do not
12 provide coverage through documents called "policies."
13 Consequently, the revised law adds a reference to
14 "evidence of coverage" because that is the name of the
15 document issued by a health maintenance organization.

16 (2) Section (a)(4), V.T.I.C. Article 3.96-7,
17 requires a health benefit plan issuer that provides
18 health coverage to provide a "health insurance
19 membership card." The revised law substitutes "health
20 coverage membership card" for the reason stated in the
21 revisor's note to Section 1504.001.

22 [Sections 1504.056-1504.100 reserved for expansion]

23 SUBCHAPTER C. PROHIBITED CONDUCT

24 Revised Law

25 Sec. 1504.101. DENIAL OF ENROLLMENT ON CERTAIN GROUNDS
26 PROHIBITED. A health benefit plan issuer may not deny enrollment
27 of a child under the health coverage of the child's parent on the
28 ground that the child:

- 29 (1) has a preexisting condition;
30 (2) was born out of wedlock;
31 (3) is not claimed as a dependent on the parent's
32 federal income tax return;
33 (4) does not reside with the parent; or
34 (5) receives or has applied for medical assistance.
35 (V.T.I.C. Art. 3.96-2 (part).)

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Source Law

Art. 3.96-2. An insurer may not deny enrollment of a child under the health insurance coverage of the child's parent on the ground that the child:
 (1) has a preexisting condition;
 (2) was born out of wedlock;
 (3) is not claimed as a dependent on the parent's federal income tax return;
 (4) does not reside with the parent or . . .
 (5) is or has been an applicant for or recipient of medical assistance.

Revised Law

Sec. 1504.102. ASSIGNMENT OF MEDICAL SUPPORT RIGHTS: DIFFERENT REQUIREMENTS PROHIBITED. A health benefit plan issuer may not require a state agency that has been assigned the rights of an individual who is eligible for medical assistance and is covered for health benefits from the issuer to comply with a requirement that is different from a requirement imposed on an agent or assignee of any other covered individual. (V.T.I.C. Art. 3.96-6, Sec. (a).)

Source Law

Art. 3.96-6. (a) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance and covered for health benefits from the insurer that are different from the requirements applicable to an agent or assignee of any other covered individual.

CHAPTER 1505. GROUP INSURANCE PLANS FOR PERSONS 65 YEARS OF AGE OR OLDER

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1 CHAPTER 1505. GROUP HEALTH INSURANCE PLANS FOR PERSONS 65 YEARS
2 OF AGE OR OLDER

3 Revised Law

4 Sec. 1505.001. DEFINITION. In this chapter, "health
5 insurer" means an insurance company authorized to provide a
6 hospital, surgical, and medical expense insurance plan in this
7 state, including:

- 8 (1) a stock insurance company;
- 9 (2) a reciprocal or interinsurance exchange;
- 10 (3) a Lloyd's plan;
- 11 (4) a fraternal benefit society;
- 12 (5) a stipulated premium company; and
- 13 (6) a mutual insurance company, including a statewide
14 mutual assessment company or a local mutual aid association.
15 (V.T.I.C. Art. 3.71, Sec. 1 (part).)

16 Source Law

17 Sec. 1. . . . insurance companies authorized to
18 [separately] do such an insurance business in this
19 state, including stock companies, reciprocals, or
20 inter-insurance exchanges, Lloyds' associations,
21 fraternal benefit societies and mutual companies of
22 all kinds, including state-wide mutual assessment
23 corporations and local mutual aid associations, and
24 stipulated premium companies, [may join together to
25 offer, sell and administer] hospital, surgical and
26 medical expense insurance plans

27 Revised Law

28 Sec. 1505.002. PLANS FOR CERTAIN PERSONS 65 YEARS OF AGE OR
29 OLDER. (a) Two or more health insurers may provide a hospital,
30 surgical, and medical expense insurance plan under a group
31 insurance policy that covers residents of this state who are at
32 least 65 years of age and the spouses of those residents.

33 (b) The participating health insurers may enter into
34 agreements regarding matters within the scope of this chapter,
35 including:

- 36 (1) premium rates;
- 37 (2) policy provisions; and
- 38 (3) sales, administrative, technical, and accounting

1 procedures.

2 (c) Each participating health insurer is subject to
3 regulation under the laws of this state and is severally liable on a
4 group insurance policy issued under this chapter. (V.T.I.C. Art.
5 3.71, Secs. 1 (part), 2 (part).)

6 Source Law

7 Art. 3.71

8 Sec. 1. Notwithstanding any contrary or
9 inconsistent provision of any law, two or more
10 [insurance companies authorized to] separately [do
11 such an insurance business in this state,] . . . may
12 join together to offer, sell and administer hospital,
13 surgical and medical expense insurance plans under a
14 group policy covering residents of this state who are
15 sixty-five (65) years of age and older and their
16 spouses on which policy each insurance carrier shall
17 be severally liable, and such companies may agree with
18 respect to premium rates, policy provisions, sales,
19 administrative, technical and accounting procedures
20 and other matters within the scope of this
21 Article. . . .

22 Sec. 2. The insurance companies participating
23 in the insurance plans authorized by this Article
24 shall be subject to regulation under the laws of this
25 state, and

26 Revisor's Note

27 Section 1, V.T.I.C. Article 3.71, refers to an
28 authorization to engage in the business of insurance
29 "[n]otwithstanding any contrary or inconsistent
30 provision of any law." The revised law omits the
31 quoted statement. The revised law is sufficient and
32 specific authority for a health insurer to act as
33 specified, and it is unnecessary to refer to other,
34 more general provisions to which the revised law acts
35 as an exception.

36 Revised Law

37 Sec. 1505.003. APPLICATION AND OTHER EVIDENCE OF INSURANCE
38 FORMS. An application, policy, certificate, or other evidence of
39 insurance form for an insurance plan under this chapter is subject
40 to Chapter 1701. (V.T.I.C. Art. 3.71, Sec. 2 (part).)

41 Source Law

42 Sec. 2. . . . the forms of the applications,
43 certificates, policies and other evidence of such
44 insurance shall be subject to the requirements of

Article 3.42 of this Insurance Code. . . .

Revised Law

Sec. 1505.004. EXECUTION OF POLICY. An authorized person may execute an insurance policy subject to this chapter on behalf of the participating health insurers. (V.T.I.C. Art. 3.71, Sec. 1 (part).)

Source Law

Sec. 1. . . . Any such policy may be executed on behalf of the insurance companies by a duly authorized person and

Revisor's Note

Section 1, V.T.I.C. Article 3.71, provides in part that a group insurance policy issued under that article is not required to be countersigned on behalf of a participating insurer by a resident agent, thus acting as an exception to the general requirement, established under former V.T.I.C. Article 21.09, that a resident agent countersign certain health insurance policies on behalf of the issuing insurer. The revised law omits this provision as unnecessary. V.T.I.C. Article 21.09 was repealed by the 75th Legislature in 1997, and there are no remaining countersignature requirements for group health insurance policies. The omitted law reads:

Sec. 1 [Any such policy may be executed on behalf of the insurance companies by a duly authorized person and] need not be countersigned on behalf of any such company by a resident agent. . . .

Revised Law

Sec. 1505.005. USE OF UNINCORPORATED ENTITY. (a) The participating health insurers may issue the group insurance policy in their own names or in the name of an unincorporated association, trust, or other organization formed for the sole purposes of this chapter and evidenced by a written contract executed by the insurers. An unincorporated association, trust, or other organization formed under this subsection may sue and be sued in the

1 name of the association, trust, or organization.

2 (b) A person licensed as a general life, accident, and
3 health agent or as a general property and casualty agent under
4 Chapter 4051 or 4054 may act in the licensed capacity in connection
5 with an insurance policy or a certificate of insurance issued by an
6 unincorporated association, trust, or other organization formed
7 under Subsection (a). The agent is not required to notify the
8 department that the person has been appointed to act for that
9 purpose. (V.T.I.C. Art. 3.71, Secs. 1 (part), 3.)

10 Source Law

11 Sec. 1. . . . Such companies may issue such
12 insurance policies in their own names or in the name of
13 an unincorporated association, trust, or other
14 organization formed for the sole purposes of this
15 Article and evidenced by a contract in writing
16 executed by the participating insurance companies,
17 and Any person who is licensed as a general
18 life, accident, and health agent or as a general
19 property and casualty agent under Article 21.07-1 or
20 21.14 of this code may act as such agent in connection
21 with policies of insurance or certificates of
22 insurance issued by any unincorporated association,
23 trust or other organization formed for the sole
24 purposes of this Article without the necessity of
25 notifying the department that such person is appointed
26 to so act.

27 Sec. 3. Any unincorporated association, trust or
28 other organization formed under the authority of this
29 Article may sue and be sued in its association, trust
30 or organization name.

31 Revisor's Note

32 Section 1, V.T.I.C. Article 3.71, validated
33 certain contracts that established unincorporated
34 associations, trusts, or other organizations to
35 provide the coverage authorized under V.T.I.C. Article
36 3.71 and that were entered into before the effective
37 date of that article. The revised law omits this
38 provision as executed because the provision served its
39 purpose on the day it took effect. Section
40 311.031(a)(2), Government Code (Code Construction
41 Act), provides that the repeal of a statute does not
42 affect any validation previously made under the
43 statute. That section applies to the revised law. The

omitted law reads:

Sec. 1. . . . any unincorporated associations, trusts, or other organizations heretofore formed for the sole purpose of this Article and evidenced by a contract in writing executed by the participating insurance companies is hereby ratified, confirmed and approved and validated from the date of its formation. . . .

Revised Law

Sec. 1505.006. REQUIRED FILINGS; DEPARTMENT APPROVAL. (a) The participating health insurers shall provide for the filing with the department on behalf of the insurers of:

(1) a copy of any contract of association or organization or trust agreement entered into by the insurers under this chapter;

(2) the schedule of premium rates to be charged for the insurance coverage; and

(3) the plan for operating and marketing the insurance.

(b) Except as provided by Subsection (c), a contract, schedule, or plan described by Subsection (a) may not be effective until approved by the commissioner.

(c) A contract, schedule, or plan described by Subsection (a) that is not approved or disapproved in a written order of the commissioner on or before the 30th day after the date on which the document is filed with the department is considered approved on the 31st day after the date of filing. (V.T.I.C. Art. 3.71, Sec. 2 (part).)

Source Law

Sec. 2. . . . There shall be filed with the State Board of Insurance by or on behalf of such companies a true copy of any contract of association or organization or trust agreement entered into by such companies pursuant to this Article, the schedule of premium rates to be charged for the insurance, and the plan for operating and marketing such insurance. No such contract, schedule or plan shall be effective unless and until approved by the State Board of Insurance, provided, however, that at the expiration of thirty days after the filing of any such contract, schedule or plan, it shall be deemed approved unless prior thereto it has been affirmatively approved or

disapproved by written order of said Board. . . .

Revisor's Note

(1) Section 2, V.T.I.C. Article 3.71, refers to the "State Board of Insurance." Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished that board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the State Board of Insurance have been changed appropriately.

(2) Section 2, V.T.I.C. Article 3.71, refers to a "true copy" of a contract. The revised law omits "true" as unnecessary because the word does not add to the clear meaning of the law. For example, a document purporting to be a copy is not a copy if it is different from the original document.

Revised Law

Sec. 1505.007. EFFECT OF COMMISSIONER DISAPPROVAL. If, after notice and public hearing, the commissioner determines under reasonable assumptions that a premium rate charged for the insurance coverage offered under this chapter or the plan for operating and marketing that insurance is excessive, inadequate, or contrary to the public interest or that any activity or practice performed in connection with the insurance is unfair, unreasonable, or contrary to the public interest, the commissioner shall:

(1) enter an order containing the commissioner's determination and disapproving the premium rate or plan or the activity or practice; and

(2) require the discontinuance of the premium rate, plan, activity, or practice within a period that is not less than 30 days after the date of the commissioner's order containing the determination. (V.T.I.C. Art. 3.71, Sec. 2 (part).)

Source Law

Sec. 2. . . . If after notice and public hearing the said Board shall at any time find that

1 under reasonable assumptions the premium rates charged
2 for such insurance, or the plan for operating and
3 marketing same are excessive, inadequate or contrary
4 to the public interest, or that any activity or
5 practice in connection with such insurance is unfair,
6 unreasonable or contrary to the public interest, it
7 shall disapprove such premium rates or plan or such
8 activity or practice and shall require the
9 discontinuance thereof within not less than thirty
10 days from the date of its order containing such
11 finding.

12 Revised Law

13 Sec. 1505.008. EXEMPTION FROM PREMIUM TAXES. Each premium
14 received for group insurance coverage authorized by this chapter is
15 exempt from any premium tax imposed by any other law of this state.
16 (V.T.I.C. Art. 3.71, Sec. 4.)

17 Source Law

18 Sec. 4. Notwithstanding any contrary or
19 inconsistent provision of any law of this state, all
20 premiums received on account of the group insurance
21 authorized by this Article are hereby expressly
22 exempted and excluded from any and all premium taxes of
23 any kind imposed by any other law of this state.

24 Revisor's Note

25 Section 4, V.T.I.C. Article 3.71, provides that
26 certain premiums are exempt from premium taxes
27 "[n]otwithstanding any contrary or inconsistent
28 provision of any law of this state." The revised law
29 omits the quoted provision for the reason stated in the
30 revisor's note to Section 1505.002.

31 Revised Law

32 Sec. 1505.009. EXEMPTION FROM CERTAIN ANTITRUST
33 REQUIREMENTS. An association, trust, or other organization formed
34 and operated in accordance with this chapter or an insurance
35 business conducted in accordance with this chapter is not
36 considered a combination in restraint of trade, an illegal
37 monopoly, or an attempt to lessen competition or fix prices
38 arbitrarily and does not otherwise violate the antitrust laws of
39 this state. (V.T.I.C. Art. 3.71, Sec. 5.)

40 Source Law

41 Sec. 5. No association, trust or other
42 organization formed and operated in accordance with
43 this Article and no insurance business conducted in

accordance with this Article shall be deemed to be a combination in restraint of trade, or an illegal monopoly, or an attempt to lessen competition or fix prices arbitrarily or to otherwise violate the anti-trust laws of this state.

CHAPTER 1506. TEXAS HEALTH INSURANCE RISK POOL

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1 CHAPTER 1506. TEXAS HEALTH INSURANCE RISK POOL

2 SUBCHAPTER A. GENERAL PROVISIONS

3 Revised Law

4 Sec. 1506.001. DEFINITIONS. In this chapter:

5 (1) "Board" means the board of directors of the pool.

6 (2) "Health benefit arrangement" means a plan,
7 program, contract, or other arrangement through which an employer
8 provides health care services, other than health care services
9 covered through a health benefit plan issuer, to the employer's
10 officers, employees, or other personnel.

11 (3) "Health benefit plan issuer" means an entity that
12 provides health benefit plan coverage in this state, including
13 stop-loss or excess loss insurance. The term includes:

14 (A) an insurance company;

15 (B) a group hospital service corporation
16 operating under Chapter 842;

17 (C) a fraternal benefit society operating under
18 Chapter 885;

19 (D) a stipulated premium company operating under
20 Chapter 884;

21 (E) a health maintenance organization;

22 (F) an approved nonprofit health corporation
23 that holds a certificate of authority under Chapter 844;

24 (G) an eligible surplus lines insurer operating
25 under Chapter 981;

26 (H) an insurer providing stop-loss or excess loss
27 insurance to physicians, health care providers, or hospitals or to
28 any benefit arrangements to the extent permitted by Section 3,
29 Employee Retirement Income Security Act of 1974 (29 U.S.C. Section
30 1002); and

31 (I) any other entity providing a plan of health
32 insurance or health benefits subject to state insurance regulation.

33 (4) "Health maintenance organization" means an entity
34 that holds a certificate of authority to operate under Chapter 843.

1 (5) "Hospital" means a hospital for which a license is
2 issued under Chapter 241, Health and Safety Code, or that is owned
3 or operated by the federal or state government.

4 (6) "Physician" means a person licensed to practice
5 medicine in this state under Subtitle B, Title 3, Occupations Code.

6 (7) "Pool" means the Texas Health Insurance Risk Pool.
7 (V.T.I.C. Art. 3.77, Secs. 2(2), (8), (9), (11), (12), (14), (16).)

8 Source Law

9 Sec. 2. In this article:

10 (2) "Board" means the board of directors
11 of the pool.

12 (8) "Health maintenance organization"
13 means a health maintenance organization that has a
14 certificate of authority to operate in this state
15 under the Texas Health Maintenance Organization Act
16 (Chapter 20A, Vernon's Texas Insurance Code).

17 (9) "Hospital" means a licensed public or
18 private institution as defined by Chapter 241, Health
19 and Safety Code, and any hospital owned or operated by
20 the federal or state government.

21 (11) "Insurer" means any entity that
22 provides health insurance in this state, including
23 stop-loss or excess loss insurance. For the purposes
24 of this article, "insurer" includes but is not limited
25 to an insurance company; a health maintenance
26 organization operating under the Texas Health
27 Maintenance Organization Act (Chapter 20A, Vernon's
28 Texas Insurance Code); an approved nonprofit health
29 corporation; a fraternal benefit society; a stipulated
30 premium insurance company; a group hospital service
31 corporation subject to Chapter 20 of this code; a
32 surplus lines carrier; an insurer providing stop-loss
33 or excess loss insurance to physicians, health care
34 providers, hospitals, or to any benefit arrangements
35 to the extent permitted by Section 3, Employee
36 Retirement Income Security Act of 1974 (29 U.S.C.
37 Section 1002); and any other entity providing a plan of
38 health insurance or health benefits subject to state
39 insurance regulation.

40 (12) "Insurance arrangement" means a plan,
41 program, contract, or other arrangement through which
42 health care services are provided by an employer to its
43 officers, employees, or other personnel but does not
44 include health care services covered through an
45 insurer.

46 (14) "Physician" means a person licensed
47 to practice medicine in this state under the Medical
48 Practice Act (Article 4495b, Vernon's Texas Civil
49 Statutes).

50 (16) "Pool" means the Texas Health
51 Insurance Risk Pool.

1 Revisor's Note

2 (1) Sections 2(3) and (4), V.T.I.C. Article
3 3.77, provide definitions of "commissioner" and
4 "department." The revised law omits those definitions
5 as unnecessary because Section 31.001 of this code
6 contains definitions for those terms that are
7 applicable throughout the code. The omitted law
8 reads:

9 (3) "Commissioner" means the
10 commissioner of insurance.

11 (4) "Department" means the
12 Texas Department of Insurance.

13 (2) Section 2(10), V.T.I.C. Article 3.77,
14 defines "insured" to mean a person who is "a resident
15 of this state and a citizen of the United States and
16 . . . eligible to receive benefits from the pool."
17 Chapter 1084, Acts of the 77th Legislature, Regular
18 Session, 2001, amended Section 10, V.T.I.C. Article
19 3.77, to allow certain individuals legally domiciled
20 in this state to be eligible to receive benefits from
21 the pool regardless of whether the individuals are
22 citizens of the United States. The revised law omits
23 the definition of "insured" because it conflicts with
24 the clear intent of the amendment to Section 10 and
25 thus was impliedly repealed. Also, the meaning of the
26 term as used in the revised law is clear without a
27 definition. The omitted law reads:

28 (10) "Insured" means a person
29 who is a resident of this state and a
30 citizen of the United States and who is
31 eligible to receive benefits from the pool.
32 The term "insured" may include dependents
33 and family members.

34 (3) Section 2(11), V.T.I.C. Article 3.77,
35 provides a definition of "insurer" and Section 2(12),
36 V.T.I.C. Article 3.77, provides a definition of
37 "insurance arrangement." The revised law substitutes
38 "health benefit plan issuer" for "insurer" because the

1 definition of "insurer" includes entities, such as
2 health maintenance organizations, that provide health
3 coverage but are not insurers. Consequently, "health
4 benefit plan issuer" is a more accurate term.
5 Likewise, the revised law substitutes "health benefit
6 arrangement" for "insurance arrangement" because the
7 definition of "insurance arrangement" refers to both
8 insurance arrangements and other arrangements for
9 health care services that are not insurance
10 arrangements. The substitution of these terms, as
11 well as related changes necessary to ensure
12 consistency in terminology, is made throughout this
13 chapter.

14 (4) Section 2(11), V.T.I.C. Article 3.77,
15 provides that the defined term "includes but is not
16 limited to" several types of entities. The phrase "but
17 is not limited to" is omitted from the revised law as
18 unnecessary because Section 311.005(13), Government
19 Code (Code Construction Act), and Section 312.011(19),
20 Government Code, provide that "includes" and
21 "including" are terms of enlargement and not of
22 limitation and do not create a presumption that
23 components not expressed are excluded. For clarity
24 and consistency, the revised law also adds for four of
25 the entities listed in Section 2(11) (an approved
26 nonprofit health corporation, a fraternal benefit
27 society, a stipulated premium company, and an eligible
28 surplus lines insurer) references to the chapters of
29 this code that provide the authority for the operation
30 of each entity. The revised law substitutes "eligible
31 surplus lines insurer" for "surplus lines carrier" for
32 consistency with the terminology used in Chapter 981
33 of this code.

34 (5) Section 2(13), V.T.I.C. Article 3.77,

1 provides a definition of "Medicare." The revised law
2 omits that definition as unnecessary because the term
3 is commonly used in other statutes of the state without
4 being defined, and its meaning is unambiguous. The
5 omitted law reads:

6 (13) "Medicare" means coverage
7 provided by Part A and Part B, Title XVIII,
8 Social Security Act (42 U.S.C. Section
9 1395c et seq.).

10 (6) Section 2(14), V.T.I.C. Article 3.77,
11 refers to the Medical Practice Act (Article 4495b,
12 Vernon's Texas Civil Statutes). That statute was
13 codified in 1999 as Subtitle B, Title 3, Occupations
14 Code. The revised law is drafted accordingly.

15 Revised Law

16 Sec. 1506.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) In
17 this chapter, "health benefit plan" means an individual or group
18 health benefit plan and includes:

19 (1) a hospital or medical expense incurred policy;
20 (2) coverage of medical or health care services
21 offered by:

22 (A) a group hospital service corporation
23 operating under Chapter 842;

24 (B) a fraternal benefit society operating under
25 Chapter 885;

26 (C) a stipulated premium company operating under
27 Chapter 884;

28 (D) a health maintenance organization;

29 (E) a multiple employer welfare arrangement
30 subject to Chapter 846; or

31 (F) an approved nonprofit health corporation
32 that holds a certificate of authority under Chapter 844; and

33 (3) any other health care plan or arrangement that
34 pays for or furnishes medical or health care services by insurance
35 or otherwise.

(b) In this chapter, "health benefit plan" does not include:

- (1) short-term insurance;
- (2) accident insurance;
- (3) a plan providing coverage only for dental or vision care;
- (4) fixed indemnity insurance, including hospital indemnity insurance;
- (5) credit insurance;
- (6) long-term care insurance;
- (7) disability income insurance;
- (8) other limited benefit coverage, including specified disease coverage;
- (9) coverage issued as a supplement to liability insurance;
- (10) insurance arising out of a workers' compensation or similar law;
- (11) automobile medical payment insurance; or
- (12) insurance coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in a liability insurance policy or equivalent self-insurance. (V.T.I.C. Art. 3.77, Sec. 2(7).)

Source Law

Sec. 2. In this article:

(7) "Health insurance" means individual or group health insurance and includes any hospital and medical expense incurred policy, a fraternal benefit society, a stipulated premium company, an approved nonprofit health corporation, health maintenance organization subscriber contract, coverage by a group hospital service plan, a multiple employer welfare arrangement subject to Subchapter I of this chapter, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise. The term does not include short-term, accident, dental-only, vision-only, fixed indemnity, including hospital indemnity insurance, credit insurance, long-term care, disability income, or other limited benefit insurance, including specified disease insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault

1 and which is statutorily required to be contained in
2 any liability insurance policy or equivalent
3 self-insurance.

4 Revisor's Note

5 (1) Section 2(7), V.T.I.C. Article 3.77,
6 defines "health insurance" to include any "health care
7 plan or arrangement that pays for or furnishes medical
8 or health care services whether by insurance or
9 otherwise." The revised law substitutes "health
10 benefit plan" for "health insurance" throughout this
11 chapter because the definition includes more than
12 insurance, and the substituted term is more accurate.
13 The revised law also makes related changes throughout
14 this chapter as necessary to ensure consistency in
15 terminology.

16 (2) Section 2(7), V.T.I.C. Article 3.77, lists
17 several entities that provide health insurance. For
18 clarity and consistency, the revised law adds for four
19 of those entities (an approved nonprofit health
20 corporation, a fraternal benefit society, a stipulated
21 premium company, and a group hospital service
22 corporation) references to the chapters of this code
23 that provide the authority for the operation of each
24 entity.

25 Revised Law

26 Sec. 1506.003. DEFINITION OF DEPENDENT. In this chapter,
27 "dependent" means:

28 (1) a resident spouse or unmarried child younger than
29 25 years of age; or

30 (2) a child who is:

31 (A) a full-time student younger than 25 years of
32 age who is financially dependent on the parent;

33 (B) 18 years of age or older and is an individual
34 for whom a person may be obligated to pay child support; or

35 (C) disabled and dependent on the parent

1 regardless of the age of the child. (V.T.I.C. Art. 3.77, Sec.
2 2(5).)

3 Source Law

4 Sec. 2. In this article:

5 (5) "Dependent" means a resident spouse or
6 unmarried child younger than 25 years of age, a child
7 who is a full-time student younger than 25 years of age
8 and who is financially dependent upon the parent, a
9 child who is 18 years of age or older and for whom a
10 person may be obligated to pay child support, or a
11 child of any age who is disabled and dependent upon the
12 parent.

13 Revised Law

14 Sec. 1506.004. AUDIT OF POOL. (a) Annually, the state
15 auditor shall conduct a special audit of the pool under Chapter 321,
16 Government Code. The special audit must include a financial audit
17 and an economy and efficiency audit.

18 (b) The state auditor shall report the cost of each audit
19 conducted under this section to the board and the comptroller. The
20 board shall remit that amount to the comptroller. (V.T.I.C. Art.
21 3.77, Sec. 15.)

22 Source Law

23 Sec. 15. (a) The state auditor shall conduct
24 annually a special audit of the pool under Chapter 321,
25 Government Code. The state auditor's report shall
26 include a financial audit and an economy and
27 efficiency audit.

28 (b) The state auditor shall report the cost of
29 each audit conducted under this article to the board
30 and the comptroller, and the board shall remit that
31 amount to the comptroller for deposit to the general
32 revenue fund.

33 Revisor's Note

34 Section 15(b), V.T.I.C. Article 3.77, requires
35 money for the cost of an audit to be remitted to the
36 comptroller "for deposit to the general revenue fund."
37 The revised law omits the quoted provision as
38 unnecessary. Section 404.094, Government Code,
39 requires all money collected or received by a state
40 agency, including the comptroller, to be deposited to
41 the credit of the general revenue fund. It is
42 unnecessary to repeat that requirement in this

chapter.

Revised Law

Sec. 1506.005. RULES. The commissioner may adopt rules necessary and proper to implement this chapter. (V.T.I.C. Art. 3.77, Sec. 8 (part).)

Source Law

Sec. 8. The commissioner . . . may adopt other rules as are necessary and proper to implement this article. . . .

Revised Law

Sec. 1506.006. COMPLAINT PROCEDURES. (a) An applicant for or participant in coverage from the pool is entitled to have complaints against the pool reviewed by a grievance committee appointed by the board.

(b) The grievance committee shall report to the board after completion of the review of each complaint.

(c) The board shall retain each written complaint concerning the pool at least until the third anniversary of the date the pool received the complaint. (V.T.I.C. Art. 3.77, Sec. 14.)

Source Law

Sec. 14. An applicant or participant in coverage from the pool is entitled to have complaints against the pool reviewed by a grievance committee appointed by the board. The grievance committee shall report to the board after completion of the review of each complaint. The board shall retain all written complaints regarding the pool at least until the third anniversary of the date the pool received the complaint.

Revised Law

Sec. 1506.007. PROVISION OF INFORMATION ABOUT POOL. (a) A health benefit plan issuer may provide to its insureds and enrollees a notice relating to the existence of the pool that contains the address from which an insured or enrollee may obtain information about the coverage offered by the pool, the eligibility for and cost of the coverage, and other information that allows an insured or enrollee to compare the issuer's health benefit plan coverage provided to the insured or enrollee with the coverage offered by the pool.

1 (b) A health benefit plan issuer providing notice under this
2 section shall provide the notice as prescribed by the commissioner.

3 (c) A health benefit plan issuer does not incur any
4 liability solely for providing notice under this section.
5 (V.T.I.C. Art. 3.77, Secs. 2(1), 16(a), (b) (part).)

6 Source Law

7 Sec. 2. In this article:

8 (1) "Benefits plan" means coverage to be
9 offered by the pool to eligible persons under Section
10 11 of this article.

11 Sec. 16. (a) An insurer may provide a
12 notification to its insureds regarding the creation of
13 the Texas Health Insurance Risk Pool and the address
14 for information on cost, coverage, eligibility, and
15 other information where an insured can compare his or
16 her current health insurance with the benefits plan
17 offered by the pool. The insurer shall not incur any
18 liability solely for providing such notification.

19 (b) An insurer providing notice under
20 Subsection (a) shall provide such notice as prescribed
21 by the commissioner. . . .

22 Revisor's Note

23 (1) Section 16(a), V.T.I.C. Article 3.77,
24 refers to an "insured." The revised law adds a
25 reference to an "enrollee" because this chapter
26 applies to health maintenance organizations and
27 similar entities. "Enrollee" is the proper term to
28 refer to an individual covered under a benefit plan
29 provided by a health maintenance organization.

30 (2) Section 16(b), V.T.I.C. Article 3.77, in the
31 second sentence, provides authority for the
32 commissioner to adopt rules to implement that section.
33 The revised law omits that provision as unnecessary
34 because Section 8 of Article 3.77, revised in relevant
35 part as Section 1506.005, provides that authority for
36 the entire article. The omitted law reads:

37 (b) . . . The commissioner may
38 promulgate rules to implement this section.

39 [Sections 1506.008-1506.050 reserved for expansion]

1 SUBCHAPTER B. BOARD OF DIRECTORS

2 Revised Law

3 Sec. 1506.051. GOVERNANCE OF POOL; BOARD MEMBERSHIP. (a)
4 The pool is governed by a board of directors.

5 (b) The board consists of nine members appointed by the
6 commissioner as follows:

7 (1) at least two, but not more than four, members must
8 be individuals who are affiliated with a health benefit plan issuer
9 authorized to write health benefit plans in this state;

10 (2) at least two of the members must be individuals or
11 the parents of individuals who are covered by the pool or are
12 reasonably expected to qualify for coverage by the pool; and

13 (3) the other members of the board may be selected from
14 individuals such as:

15 (A) a physician licensed to practice in this
16 state by the Texas State Board of Medical Examiners;

17 (B) a hospital administrator;

18 (C) an advanced nurse practitioner; or

19 (D) a representative of the public who is not:

20 (i) employed by or affiliated with an
21 insurance company or insurance plan, group hospital service
22 corporation, or health maintenance organization; or

23 (ii) licensed as, employed by, or
24 affiliated with a physician, hospital, or other health care
25 provider.

26 (c) For purposes of Subsection (b), an individual who is
27 required to register under Chapter 305, Government Code, because of
28 the individual's activities with respect to health benefit
29 plan-related matters is affiliated with a health benefit plan
30 issuer.

31 (d) An individual is not disqualified under Subsection
32 (b)(3)(D)(i) from representing the public if the individual's only
33 affiliation with an insurance company or insurance plan, group
34 hospital service corporation, or health maintenance organization

1 is as an insured or as an individual who has coverage through a plan
2 provided by the corporation or organization. (V.T.I.C. Art. 3.77,
3 Secs. 4(a), (b) (part), (c), (d).)

4 Source Law

5 Sec. 4. (a) The pool is governed by a board of
6 directors composed of nine members.

7 (b) The commissioner shall appoint members of
8 the board . . . as provided by this section.

9 (c) The board shall be composed of:

10 (1) at least two persons affiliated with
11 an insurer admitted and authorized to write health
12 insurance in this state, but no more than four such
13 persons;

14 (2) at least two persons who are insureds
15 or parents of insureds or who are reasonably expected
16 to qualify for coverage by the pool;

17 (3) the remaining members of the board may
18 be selected from individuals such as a physician
19 licensed to practice in this state by the Texas State
20 Board of Medical Examiners, a hospital administrator,
21 an advanced nurse practitioner, or representatives of
22 the general public who are not employed by or
23 affiliated with an insurance company or plan, group
24 hospital service corporation, or health maintenance
25 organization or licensed as or employed by or
26 affiliated with a physician, hospital, or other health
27 care provider. A representative of the general public
28 does include a person whose only affiliation with an
29 insurance company or plan, group hospital service
30 corporation, or health maintenance organization is as
31 an insured or person who has coverage through a plan
32 provided by the corporation or organization.

33 (d) For purposes of this section, an individual
34 required to register with the secretary of state under
35 Chapter 305, Government Code, because of the
36 individual's activities with respect to health
37 insurance-related matters is a person affiliated with
38 an insurer.

39 Revisor's Note

40 Section 4(d), V.T.I.C. Article 3.77, refers to an
41 individual "required to register with the secretary of
42 state under Chapter 305, Government Code." The
43 revised law omits the reference to the secretary of
44 state because under Chapter 304, Acts of the 72nd
45 Legislature, Regular Session, 1991, an individual
46 formerly required to register with the secretary of
47 state must now register with the Texas Ethics
48 Commission under Chapter 305, Government Code. A
49 reference to the Texas Ethics Commission is
50 unnecessary because Chapter 305, Government Code,

1 provides for registration only with that agency.

2 Revised Law

3 Sec. 1506.052. PRESIDING OFFICER. The commissioner shall
4 designate one member of the board to serve as presiding officer at
5 the pleasure of the commissioner. (V.T.I.C. Art. 3.77, Sec. 4(g).)

6 Source Law

7 (g) The commissioner shall designate one of the
8 commissioner's appointees to the board to serve as
9 chairman. The chairman serves in that capacity at the
10 pleasure of the commissioner.

11 Revisor's Note

12 Section 4(g), V.T.I.C. Article 3.77, refers to
13 the "chairman" of the board. The revised law
14 substitutes "presiding officer" for that term because,
15 in context, the term has the same meaning, and
16 "presiding officer" is more modern and is gender
17 neutral.

18 Revised Law

19 Sec. 1506.053. TERMS; VACANCY. (a) Members of the board
20 serve staggered six-year terms.

21 (b) The commissioner shall fill a vacancy on the board by
22 appointing, for the unexpired term, an individual who has the
23 appropriate qualifications to fill that position. (V.T.I.C. Art.
24 3.77, Secs. 4(b) (part), (e).)

25 Source Law

26 (b) . . . for staggered six-year terms

27 (e) If a vacancy occurs on the board, the
28 commissioner shall fill the vacancy for the unexpired
29 term with a person who has the appropriate
30 qualifications to fill that position on the board.

31 Revised Law

32 Sec. 1506.054. PER DIEM; REIMBURSEMENT. A member of the
33 board is entitled to:

34 (1) a per diem in the amount provided by the General
35 Appropriations Act for state officials for each day the member
36 performs duties as a board member; and

37 (2) reimbursement of expenses incurred while

1 performing duties as a board member in the amount provided by the
2 General Appropriations Act for state officials. (V.T.I.C. Art.
3 3.77, Sec. 4(f).)

4 Source Law

5 (f) Each member of the board is entitled to be
6 paid a per diem for each day on which the member
7 performs his duties as a member of the board and to
8 reimbursement of his expenses while engaged in
9 performing his duties as a member of the board. The
10 amount of per diem and the amount of reimbursement for
11 expenses is the same as provided by the General
12 Appropriations Act for state officials.

13 Revised Law

14 Sec. 1506.055. MEMBER'S IMMUNITY. (a) A member of the
15 board is not liable for an act or omission made in good faith in the
16 performance of powers and duties under this chapter.

17 (b) A cause of action does not arise against a member of the
18 board for an act or omission described by Subsection (a). (V.T.I.C.
19 Art. 3.77, Sec. 4(h).)

20 Source Law

21 (h) A member of the board of directors is not
22 liable for an action or omission performed in good
23 faith in the performance of powers and duties under
24 this article, and cause of action does not arise
25 against a member for the action or omission.

26 Revised Law

27 Sec. 1506.056. ADJUSTMENTS. (a) The board may adjust
28 deductibles, the amounts of stop-loss coverage, and the periods
29 governing preexisting conditions under Section 1506.155 to
30 preserve the financial integrity of the pool.

31 (b) Not later than the 30th day after the date the board
32 makes an adjustment under this section, the board shall submit to
33 the commissioner a written report containing a description of and
34 the reasons for the adjustment. (V.T.I.C. Art. 3.77, Sec. 11(c).)

35 Source Law

36 (c) The board may adjust deductibles, the
37 amounts of stop-loss coverage, and the time periods
38 governing preexisting conditions under Section 12 of
39 this article to preserve the financial integrity of
40 the pool. If the board makes such an adjustment it
41 shall report in writing that adjustment together with
42 its reasons for the adjustment to the commissioner.
43 The report must be submitted not later than the 30th

1 day after the date the adjustment is made.

2 Revised Law

3 Sec. 1506.057. ANNUAL REPORT OF POOL'S ACTIVITIES. (a) Not
4 later than June 1 of each year, the board shall submit a report to
5 the governor, the lieutenant governor, the speaker of the house of
6 representatives, and the commissioner.

7 (b) The report must summarize the activities of the pool in
8 the calendar year preceding the year in which the report is
9 submitted and must include information relating to net written and
10 earned premiums, plan enrollment, administration expenses, and
11 paid and incurred losses. (V.T.I.C. Art. 3.77, Sec. 6(d).)

12 Source Law

13 (d) Not later than June 1 of each year, the board
14 shall make an annual report to the governor, the
15 lieutenant governor, the speaker of the house of
16 representatives, and the commissioner. The report
17 shall summarize the activities of the pool in the
18 preceding calendar year, including information
19 regarding net written and earned premiums, plan
20 enrollment, administration expenses, and paid and
21 incurred losses.

22 Revisor's Note

23 Section 6(d), V.T.I.C. Article 3.77, refers to an
24 "annual report" and requires that it be filed not later
25 than "June 1 of each year." The revised law omits
26 "annual" as unnecessary because the law requires the
27 report to be submitted each year and describes the
28 period to be covered by the report.

29 Revised Law

30 Sec. 1506.058. ADDITIONAL POWERS AND DUTIES. The
31 commissioner by rule may establish powers and duties of the board in
32 addition to those provided by this chapter. (V.T.I.C. Art. 3.77,
33 Sec. 8 (part).)

34 Source Law

35 Sec. 8. The commissioner may by rule establish
36 additional powers and duties of the board and

37 Revisor's Note
38 (End of Subchapter)

39 The revised law omits Section 3, V.T.I.C. Article

1 3.77, relating to the creation of the Texas Health
2 Insurance Risk Pool, as executed. The omitted law
3 reads:

4 Sec. 3. The Texas Health Insurance
5 Risk Pool is created.

6 [Sections 1506.059-1506.100 reserved for expansion]

7 SUBCHAPTER C. POWERS AND DUTIES OF POOL

8 Revised Law

9 Sec. 1506.101. PURPOSES OF POOL. (a) The purposes of the
10 pool are to:

11 (1) provide for access to quality health care at
12 minimum cost to the public;

13 (2) relieve the insurable population of the disruptive
14 cost of sharing coverage; and

15 (3) maximize reliance on strategies of managed care
16 proven by the private sector.

17 (b) The pool is not intended to diminish the availability of
18 traditional health care coverage to consumers who are eligible for
19 that coverage. (V.T.I.C. Art. 3.77, Secs. 1(c), (d).)

20 Source Law

21 (c) To provide for access to quality health care
22 at minimum cost to the public, to relieve the insurable
23 population of the disruptive cost of sharing coverage,
24 and to maximize reliance on strategies of managed care
25 proven by the private sector, the legislature hereby
26 authorizes the Texas Health Insurance Risk Pool.

27 (d) The creation of the Texas Health Insurance
28 Risk Pool is not intended to diminish the availability
29 of traditional health care insurance to consumers who
30 currently are eligible for these policies.

31 Revisor's Note

32 Sections 1(a) and (b), V.T.I.C. Article 3.77,
33 contain legislative findings relating to the lack of
34 availability of health insurance. The revised law
35 omits the findings because they are executed. The
36 omitted law reads:

37 Art. 3.77

38 Sec. 1. (a) The legislature finds
39 that medically uninsurable Texans face
40 critical problems with respect to health
41 care coverage, access to care, job

1 mobility, and family impoverishment arising
2 from their health status.

3 (b) Competitive forces in the
4 marketplaces for health care and health
5 insurance will operate over time to
6 increase the number of medically
7 uninsurable persons.

8 Revised Law

9 Sec. 1506.102. EMPLOYEES; COMMITTEES. (a) The pool may
10 employ and set the compensation of any persons necessary to assist
11 the pool in carrying out its responsibilities and functions.

12 (b) The pool may appoint appropriate legal, actuarial, and
13 other committees necessary to provide technical assistance in
14 operating the pool and performing any of the functions of the pool.
15 (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

16 Source Law

17 (b) As part of its authority, the pool may:

18 . . .
19 (8) appoint appropriate legal, actuarial,
20 and other committees that are necessary to provide
21 technical assistance in operating the pool and
22 performing any of the functions of the pool;

23 (9) employ and set the compensation of any
24 persons necessary to assist the pool in carrying out
25 its responsibilities and functions;

26 . . .

27 Revised Law

28 Sec. 1506.103. PROVIDING COVERAGE. (a) The pool may
29 provide health benefit coverage to an individual who is eligible
30 for that coverage under this chapter.

31 (b) The pool may issue health benefit coverage subject to
32 this chapter and the pool's plan of operation under Section
33 1506.201.

34 (c) The pool may issue additional types of health benefit
35 coverage to provide optional coverages that comply with applicable
36 provisions of state and federal law, including a Medicare
37 supplement benefit plan. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

38 Source Law

39 (b) As part of its authority, the pool may:

40 (1) provide health benefits coverage to
41 persons who are eligible for that coverage under this
42 article;

43 . . .
44 (7) issue insurance policies subject to
45 this article and the plan of operation;

1 . . .
2 (13) issue additional types of health
3 insurance policies to provide optional coverages which
4 comply with applicable provisions of state and federal
5 law, including Medicare supplemental health
6 insurance;
7 . . .

8 Revisor's Note

9 Section 6(b)(13), V.T.I.C. Article 3.77, refers
10 to "Medicare supplemental health insurance." The
11 revised law substitutes "Medicare supplement benefit
12 plan" because V.T.I.C. Article 3.77, revised as this
13 chapter, applies to evidences of coverage issued by
14 health maintenance organizations to supplement
15 reimbursements under Medicare. Health maintenance
16 organizations provide health benefit coverage, but the
17 organizations are not insurers. Consequently,
18 "benefit plan" is a more accurate term than
19 "insurance." The substitution of "benefit plan" in
20 this context, as well as any comparable change
21 necessary to ensure consistency in terminology, is
22 made throughout this chapter.

23 Revised Law

24 Sec. 1506.104. CHARGES, FORMULAS, AND FORMS. (a) The pool
25 may establish appropriate rates, rate schedules, rate adjustments,
26 expense allowances, agents' referral fees, and claim reserve
27 formulas and perform actuarial functions appropriate to the
28 operation of the pool.

29 (b) The pool may adopt policy forms, endorsements, and
30 riders and applications for coverage. (V.T.I.C. Art. 3.77, Sec.
31 6(b) (part).)

32 Source Law

33 (b) As part of its authority, the pool may:

34 . . .
35 (5) establish appropriate rates, rate
36 schedules, rate adjustments, expense allowances,
37 agents' referral fees, and claim reserve formulas and
38 perform any actuarial functions appropriate to the
39 operation of the pool;

40 (6) adopt policy forms, endorsements, and
41 riders and applications for coverage;
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(f) The pool shall submit each rate and rate schedule to the commissioner for approval. The pool may not use a rate or rate schedule before the rate or schedule is approved by the commissioner. In evaluating a rate or rate schedule of the pool, the commissioner shall consider the factors provided by this section. (V.T.I.C. Art. 3.77, Sec. 9.)

33

34

Sec. 9. (a) Rates charged by the pool may not

1 be unreasonable in relation to the coverage provided
2 and the risk experience and expenses of providing the
3 coverage.

4 (b) Rates and rate schedules may be adjusted for
5 appropriate risk factors including age and variation
6 in claim costs, and the board may consider appropriate
7 risk factors in accordance with established actuarial
8 and underwriting practices.

9 (c) Premiums charged for pool coverage may not
10 be unreasonable in relation to the benefits provided,
11 the risk experience, and the reasonable expenses of
12 providing the coverage. Separate schedules of premium
13 rates based on age, sex, and geographic location may
14 apply for individual risks.

15 (d) The pool shall determine the standard risk
16 rate by considering the premium rates charged by other
17 insurers offering health insurance coverage to
18 individuals. The standard risk rate shall be
19 established using reasonable actuarial techniques,
20 and shall reflect anticipated experience and expenses
21 for such coverage. Initial pool rates may not be less
22 than 125 percent and may not exceed 150 percent of
23 rates established as applicable for individual
24 standard rates. Subsequent rates shall be established
25 to provide fully for the expected costs of claims
26 including recovery of prior losses, expenses of
27 operation, investment income of claim reserves, and
28 any other cost factors subject to the limitations
29 described in this subsection. In no event shall pool
30 rates exceed 200 percent of rates applicable to
31 individual standard risks.

32 (e) All rates and rate schedules shall be
33 submitted to the commissioner for approval, and the
34 commissioner must approve the rates and rate schedules
35 of the pool before they are used by the pool. The
36 commissioner in evaluating the rates and rate
37 schedules of the pool shall consider the factors
38 provided by this section.

39 Revised Law

40 Sec. 1506.106. REINSURANCE. The pool may provide for
41 reinsurance on a facultative or treaty basis or on both facultative
42 and treaty bases. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

43 Source Law

44 (b) As part of its authority, the pool may:

45 . . .
46 (16) provide for reinsurance on either a
47 facultative or treaty basis or both.

48 Revised Law

49 Sec. 1506.107. CONTRACTS. (a) The pool may enter into a
50 contract that is necessary to carry out this chapter, including,
51 with the approval of the commissioner, a contract with:

52 (1) a similar pool in another state for the joint
53 performance of common administrative functions; or

54 (2) another organization for the performance of

1 administrative functions.

2 (b) The pool may contract for stop-loss insurance for risks
3 incurred by the pool. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

4 Source Law

5 (b) As part of its authority, the pool may:

6 . . .
7 (2) enter into contracts that are
8 necessary to carry out this article including, with
9 the approval of the commissioner, entering into
10 contracts with similar pools in other states for the
11 joint performance of common administrative functions
12 or with other organizations for the performance of
13 administrative functions;

14 . . .
15 (10) contract for stop-loss insurance for
16 risks incurred by the pool;

17 . . .

18 Revised Law

19 Sec. 1506.108. LEGAL ACTION. (a) The pool may sue or be
20 sued.

21 (b) The pool may take any legal action necessary to:

22 (1) avoid payment of improper claims against the pool
23 or the coverage provided by or through the pool; or

24 (2) recover or collect amounts due the pool,
25 including:

26 (A) assessments due the pool;

27 (B) amounts erroneously or improperly paid by the
28 pool; and

29 (C) amounts paid by the pool as a mistake of fact
30 or law. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

31 Source Law

32 (b) As part of its authority, the pool may:

33 . . .
34 (3) sue or be sued, including taking any
35 legal actions necessary or proper to recover or
36 collect assessments due the pool;

37 (4) institute any legal action necessary
38 to avoid payment of improper claims against the pool or
39 the coverage provided by or through the pool, to
40 recover any amounts erroneously or improperly paid by
41 the pool, to recover any amounts paid by the pool as a
42 mistake of fact or law, and to recover other amounts
43 due the pool;

44 . . .

45 Revised Law

46 Sec. 1506.109. COST CONTAINMENT. (a) The pool may provide

1 for and use cost containment measures and requirements, including
2 preadmission screening, the requirement of a second surgical
3 opinion, concurrent utilization review subject to Article 21.58A,
4 and individual case management, to make the coverage offered by the
5 pool more cost-effective.

6 (b) The pool may design, use, contract for, or otherwise
7 arrange for the delivery of cost-effective health care services,
8 including establishing or contracting with preferred provider
9 organizations and health maintenance organizations. (V.T.I.C.
10 Art. 3.77, Secs. 2(1), 6(b) (part).)

11 Source Law

12 Sec. 2. In this article:

13 (1) "Benefits plan" means coverage to be
14 offered by the pool to eligible persons under Section
15 11 of this article.

16 [Sec. 6]

17 (b) As part of its authority, the pool may:

18 . . .
19 (14) provide for and employ cost
20 containment measures and requirements including, but
21 not limited to, preadmission screening, second
22 surgical opinion, concurrent utilization review
23 subject to Article 21.58A of this code, and individual
24 case management for the purpose of making the benefit
25 plans more cost effective;

26 (15) design, utilize, contract, or
27 otherwise arrange for the delivery of cost-effective
28 health care services, including establishing or
29 contracting with preferred provider organizations and
30 health maintenance organizations; and
31 . . .

32 Revisor's Note

33 Section 6(b)(14), V.T.I.C. Article 3.77,
34 contains a list of cost containment measures,
35 "including, but not limited to," certain specified
36 items. The phrase "but not limited to" is omitted from
37 the revised law for the reason stated in Revisor's Note
38 (4) to Section 1506.001.

39 Revised Law

40 Sec. 1506.110. BORROWING. The pool may borrow money as
41 necessary to implement the purposes of the pool. (V.T.I.C. Art.
42 3.77, Sec. 6(b) (part).)

1 Source Law

2 (b) As part of its authority, the pool may:
3 . . .
4 (12) borrow money as necessary to
5 implement the purposes of the pool;
6 . . .

7 Revised Law

8 Sec. 1506.111. ADDITIONAL AUTHORITY. In addition to the
9 other powers granted to the pool under this chapter, the pool may
10 exercise any of the authority that a health benefit plan issuer
11 authorized to write health benefit plans in this state may exercise
12 under the law of this state. (V.T.I.C. Art. 3.77, Sec. 6(a).)

13 Source Law

14 Sec. 6. (a) The pool may exercise any of the
15 authority that an insurance company authorized to
16 write health insurance in this state may exercise
17 under the law of this state.

18 [Sections 1506.112-1506.150 reserved for expansion]

19 SUBCHAPTER D. POOL COVERAGE AND BENEFITS

20 Revised Law

21 Sec. 1506.151. MINIMUM POOL COVERAGE. (a) The pool shall
22 offer coverage consistent with major medical expense coverage to
23 each eligible individual who is not eligible for Medicare.

24 (b) The board, with the approval of the commissioner, shall
25 establish:

- 26 (1) the coverages to be provided by the pool;
27 (2) the applicable schedules of benefits; and
28 (3) any exclusions to coverage and other limitations.

29 (c) The benefits provisions of the pool's coverage must
30 include:

- 31 (1) all required or applicable definitions;
32 (2) a description of covered services required under
33 the pool;
34 (3) a list of any exclusions or limitations to
35 coverage; and
36 (4) the deductibles, coinsurance options, and
37 copayment options that are required or permitted. (V.T.I.C. Art.
38 3.77, Secs. 11(a), (b).)

1 issue, substantially similar individual health benefit plan
2 coverage from a health benefit plan issuer, other than an insurer
3 that offers only stop-loss, excess loss, or reinsurance coverage,
4 if the rejection or refusal was for health reasons;

5 (B) certification from an agent or salaried
6 representative of a health benefit plan issuer that states that the
7 agent or salaried representative cannot obtain substantially
8 similar individual coverage for the individual from any health
9 benefit plan issuer that the agent or salaried representative
10 represents because, under the underwriting guidelines of the health
11 benefit plan issuer, the individual will be denied coverage as a
12 result of a medical condition of the individual;

13 (C) an offer to issue substantially similar
14 individual coverage only with conditional riders;

15 (D) a notice of refusal by a health benefit plan
16 issuer to issue substantially similar individual coverage except at
17 a rate exceeding the pool rate; or

18 (E) a diagnosis of the individual with one of the
19 medical or health conditions on the list adopted under Section
20 1506.154.

21 (b) Each dependent of an individual who is eligible for
22 coverage from the pool is also eligible for coverage from the pool.

23 (c) If an individual who obtains coverage from the pool
24 under Subsection (a) is a child, each parent, grandparent,
25 brother, sister, or child of that individual who resides with that
26 individual is also eligible for coverage from the pool.

27 (d) The board shall develop a form to be used for
28 certification under Subsection (a)(3)(B). Before it may be used,
29 the form must be approved by the commissioner. (V.T.I.C. Art. 3.77,
30 Secs. 2(6), (17), 10(a), (b), (c).)

31 Source Law

32 [Sec. 2]

33 (6) "Family member" means a parent,
34 grandparent, brother, sister, or child of a dependent
35 residing with the insured.

1 (17) "Resident" means:
2 (A) an individual who has been
3 legally domiciled in Texas for a minimum of 30 days for
4 persons eligible for enrollment in the pool under
5 Section 10(b) of this article; or
6 (B) an individual who is legally
7 domiciled in Texas for persons eligible for enrollment
8 in the pool under Section 10(a) of this article.

9 Sec. 10. (a) An individual who is a resident,
10 as defined by Section 2(17)(B) of this article, and who
11 continues to be a resident, is eligible for coverage
12 from the pool if the individual:

13 (1) provides to the pool evidence that the
14 individual has maintained health insurance coverage
15 for the previous 18 months, with no gap in coverage
16 greater than 63 days, of which the most recent coverage
17 was through an employer-sponsored plan, church plan,
18 or government plan; or

19 (2) provides to the pool evidence that the
20 individual had health insurance coverage under another
21 state's qualified Health Insurance Portability and
22 Accountability Act health program that was terminated
23 because the individual did not reside in that state and
24 submits an application for pool coverage not later
25 than the 63rd day after the date that coverage was
26 terminated.

27 (b) Any individual who is and continues to be a
28 resident, as defined by Section 2(17)(A) of this
29 article, and who is a citizen of the United States or
30 has been a permanent resident of the United States for
31 at least three continuous years is eligible for
32 coverage from the pool if the individual provides to
33 the pool:

34 (1) a notice of rejection or refusal to
35 issue substantially similar individual insurance for
36 health reasons by one insurer, other than a rejection
37 or refusal by an insurer offering only stop-loss,
38 excess loss, or reinsurance coverage;

39 (2) a certification from an agent or
40 salaried representative of an insurer, on a form
41 developed by the board and approved by the
42 commissioner, that states that the agent or salaried
43 representative is unable to obtain substantially
44 similar individual insurance for the individual with
45 any state-licensed insurer that the agent or salaried
46 representative represents because the individual will
47 be declined for coverage as a result of a medical
48 condition of the individual under the underwriting
49 guidelines of the insurer;

50 (3) an offer to issue substantially
51 similar individual insurance only with conditional
52 riders;

53 (4) a refusal by an insurer to issue
54 substantially similar individual insurance except at a
55 rate exceeding the pool rate; or

56 (5) diagnosis of the individual with one
57 of the medical or health conditions listed by the board
58 under Section 6(c) of this article and for which a
59 person shall be eligible for pool coverage.

60 (c) Each dependent of a person who is eligible
61 for coverage from the pool shall also be eligible for
62 coverage from the pool. In the instance of a child who
63 is the primary insured, resident family members shall
64 also be eligible for coverage.

1 Revisor's Note

2 (1) Section 10, V.T.I.C. Article 3.77, refers to
3 an individual who is a resident and "continues to be a
4 resident." The revised law omits the quoted language
5 as unnecessary because an individual is a resident
6 only as long as the individual continues to be a
7 resident. Also, Section 10(f), V.T.I.C. Article 3.77,
8 revised as Section 1506.158, expressly states that an
9 individual's pool coverage generally ends on the date
10 the individual ceases to be a resident.

11 (2) Section 10(b)(2), V.T.I.C. Article 3.77,
12 refers to a "state-licensed insurer." "State-licensed
13 insurer" refers to any foreign or domestic entity that
14 has authority from the Texas Department of Insurance
15 to engage in insurance business in this state and is
16 equivalent to "insurer," as defined by Section 2(11),
17 V.T.I.C. Article 3.77. The revised law substitutes
18 "health benefit plan issuer" for "state-licensed
19 insurer" for the reason stated in Revisor's Note (3) to
20 Section 1506.001.

21 Revised Law

22 Sec. 1506.153. INELIGIBILITY FOR COVERAGE.
23 Notwithstanding Section 1506.152, an individual is not eligible for
24 coverage from the pool if:

25 (1) on the date pool coverage is to take effect, the
26 individual has health benefit plan coverage from a health benefit
27 plan issuer or health benefit arrangement in effect;

28 (2) at the time the individual applies to the pool, the
29 individual is eligible for other health care benefits, including
30 benefits from the continuation of coverage under Title X,
31 Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C.
32 Section 1161 et seq.), as amended (COBRA), other than:

33 (A) coverage, including COBRA or other
34 continuation coverage or conversion coverage, maintained for any

1 preexisting condition waiting period under a pool policy;

2 (B) employer group coverage conditioned by a
3 limitation of the kind described by Section 1506.152(a)(3)(A) or
4 (C); or

5 (C) individual coverage conditioned by a
6 limitation described by Section 1506.152(a)(3)(C) or (D);

7 (3) within 12 months before the date the individual
8 applies to the pool, the individual terminated coverage in the
9 pool, unless the individual demonstrates a good faith reason for
10 the termination;

11 (4) the individual is confined in a county jail or
12 imprisoned in a state prison;

13 (5) any of the individual's premiums are paid for or
14 reimbursed under a government-sponsored program or by a government
15 agency or health care provider, other than as an otherwise
16 qualifying full-time employee of a government agency or health care
17 provider or as a dependent of such an employee;

18 (6) the individual's prior coverage with the pool was
19 terminated:

20 (A) during the 12-month period preceding the date
21 of application for nonpayment of premiums; or

22 (B) for fraud; or

23 (7) the individual is eligible for health benefit plan
24 coverage provided in connection with a policy, plan, or program
25 paid for or sponsored by an employer, even though the employer
26 coverage is declined. (V.T.I.C. Art. 3.77, Secs. 10(e), (h)
27 (part).)

28 Source Law

29 (e) A person is not eligible for coverage from
30 the pool if the person:

31 (1) has in effect on the date pool coverage
32 takes effect health insurance coverage from an insurer
33 or insurance arrangement;

34 (2) is eligible for other health care
35 benefits at the time application is made to the pool,
36 including COBRA continuation, except:

37 (A) coverage, including COBRA
38 continuation, other continuation or conversion
39 coverage, maintained for the period of time the person

1 is satisfying any pre-existing condition waiting
2 period under a pool policy; or

3 (B) employer group coverage
4 conditioned by the type of limitations described by
5 Subsections (b)(1) or (3) of this section; or

6 (C) individual coverage conditioned
7 by the limitations described by Subsections (b)(3) or
8 (4) of this section;

9 (3) has terminated coverage in the pool
10 within 12 months of the date that application is made
11 to the pool, unless the person demonstrates a good
12 faith reason for the termination;

13 (4) is confined in a county jail or
14 imprisoned in a state prison;

15 (5) has premiums that are paid for or
16 reimbursed under any government sponsored program or
17 by any government agency or health care provider,
18 except as an otherwise qualifying full-time employee,
19 or dependent thereof, of a government agency or health
20 care provider;

21 (6) has had prior coverage with the pool
22 terminated during the 12 months immediately preceding
23 the date of application for nonpayment of premiums; or

24 (7) has had prior coverage with the pool
25 terminated for fraud.

26 (h) A person who is eligible for health
27 insurance benefits provided in connection with a
28 policy, plan, or program paid for or sponsored by an
29 employer, even though the employer coverage is
30 declined, is not eligible for pool coverage. . . .

31 Revisor's Note

32 Section 10(e), V.T.I.C. Article 3.77, makes
33 several references to COBRA continuation of health
34 care coverage. While COBRA is an acronym that is used
35 with some frequency, for clarity the revised law adds
36 the name of the federal statute, the Consolidated
37 Omnibus Budget Reconciliation Act of 1985, and its
38 citation at the first reference to COBRA.

39 Revised Law

40 Sec. 1506.154. LIST OF COVERED CONDITIONS. (a) The board
41 shall adopt a list of medical or health conditions for which an
42 individual is eligible for pool coverage under Section
43 1506.152(a)(3)(E) without applying for health benefit plan
44 coverage.

45 (b) The board may amend the list as appropriate. (V.T.I.C.
46 Art. 3.77, Sec. 6(c) (part).)

47 Source Law

48 (c) The board shall promulgate a list of medical
49 or health conditions for which a person shall be

1 eligible for pool coverage without applying for health
2 insurance. The list . . . may be amended from time to
3 time as may be appropriate.

4 Revisor's Note

5 (1) Section 6(c), V.T.I.C. Article 3.77,
6 provides that the board may amend the list of
7 conditions required by that section "from time to
8 time." The revised law omits the quoted language as
9 unnecessary because the power to take an action
10 includes the power to act "from time to time."

11 (2) The part of Section 6(c), V.T.I.C. Article
12 3.77, that relates to the date on which the initial
13 list of conditions became effective is omitted from
14 the revised law as executed. The omitted law reads:

15 (c) . . . [The list] shall be
16 effective on the first day of the operation
17 of the pool and

18 Revised Law

19 Sec. 1506.155. PREEXISTING CONDITIONS. (a) Except as
20 provided by this section and Section 1506.056, pool coverage
21 excludes charges or expenses incurred before the first anniversary
22 of the effective date of coverage with regard to any condition for
23 which medical advice, care, or treatment was recommended or
24 received during the six-month period preceding the effective date
25 of coverage.

26 (b) The exclusion provided by Subsection (a) does not apply
27 to an individual who:

28 (1) was continuously covered for a period of at least
29 12 months, excluding any waiting period, by health benefit plan
30 coverage that terminated not earlier than the 63rd day before the
31 effective date of coverage under the pool; and

32 (2) applied for pool coverage not later than the 63rd
33 day after the date the health benefit plan coverage described by
34 Subdivision (1) terminated.

35 (c) If an individual was covered by health benefit plan
36 coverage that was in effect at any time during the 12-month period

preceding the effective date of the individual's coverage under the pool, the pool shall subtract from the exclusion period required under Subsection (a) the period that the individual was covered under that health benefit plan and any waiting period that applied before that health benefit plan coverage became effective. (V.T.I.C. Art. 3.77, Sec. 12.)

Source Law

Sec. 12. (a) Except as provided by this section and Section 11(c) of this article, pool coverage shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage with regard to any condition for which medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage.

(b) A preexisting condition provision shall not apply to an individual who was continuously covered for an aggregate period of 12 months by health insurance that was in effect up to a date not more than 63 days before the effective date of coverage under the pool, excluding any waiting period, provided that the application for pool coverage is made no later than 63 days following the termination of coverage.

(c) In determining whether a preexisting condition provision applies to an individual covered by the pool, the pool shall credit the time the individual was previously covered under health insurance if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under the pool. Any waiting period that applied before that coverage became effective also shall be credited against the preexisting condition provision period.

Revised Law

Sec. 1506.156. BENEFIT REDUCTION. The pool shall reduce benefits otherwise payable under pool coverage by:

(1) the total amount paid or payable through any other health benefit plan or health benefit arrangement; and

(2) the total amount of hospital or medical expense benefits paid or payable under:

(A) workers' compensation coverage;

(B) automobile insurance, regardless of whether provided on the basis of fault or no fault; or

(C) a state or federal law or program. (V.T.I.C. Art. 3.77, Sec. 11(d).)

1 Source Law

2 (d) Benefits otherwise payable under pool
3 coverage shall be reduced by amounts paid or payable
4 through any other health insurance, or insurance
5 arrangement, and by all hospital and medical expense
6 benefits paid or payable under any workers'
7 compensation coverage, automobile insurance whether
8 provided on the basis of fault or no-fault, and by any
9 hospital or medical benefits paid or payable under or
10 provided pursuant to any state or federal law or
11 program.

12 Revised Law

13 Sec. 1506.157. RECOVERY OF CERTAIN AMOUNTS. (a) The pool
14 has a cause of action against an eligible individual for the
15 recovery of the amount of benefits paid that are not for covered
16 expenses.

17 (b) Benefits due from the pool may be reduced or refused as
18 an offset against an amount recoverable under this section.
19 (V.T.I.C. Art. 3.77, Sec. 11(e).)

20 Source Law

21 (e) The pool has a cause of action against an
22 eligible person for the recovery of the amount of
23 benefits paid that are not for covered expenses.
24 Benefits due from the pool may be reduced or refused as
25 an offset against any amount recoverable under this
26 subsection.

27 Revised Law

28 Sec. 1506.158. TERMINATION OF POOL COVERAGE. (a) An
29 individual's pool coverage ends:

30 (1) on the date the individual ceases to be a legally
31 domiciled resident of this state, unless the individual:

32 (A) is a student younger than 25 years of age and
33 is financially dependent on the parent;

34 (B) is a child for whom an individual may be
35 obligated to pay child support; or

36 (C) is a child who is disabled and dependent on
37 the parent, regardless of the age of the child;

38 (2) on the date the individual requests coverage to
39 end;

40 (3) on the date the individual covered by the pool
41 dies;

1 (4) on the date state law requires cancellation of the
2 coverage;

3 (5) at the option of the pool, on the 31st day after
4 the date the pool sends to the individual any inquiry concerning the
5 individual's eligibility, including an inquiry concerning the
6 individual's residence, to which the individual does not reply;

7 (6) on the 31st day after the date a premium payment
8 for pool coverage becomes due if the payment is not made before that
9 day; or

10 (7) at the time the individual ceases to meet the
11 eligibility requirements for coverage.

12 (b) Notwithstanding Subsection (a), the coverage of an
13 individual who ceases to meet the eligibility requirements for
14 coverage terminates on the earlier of:

15 (1) the first premium due date after the date the pool
16 determines the individual does not meet the eligibility
17 requirements; or

18 (2) the first day of the first month after the month in
19 which the pool determines the individual does not meet the
20 eligibility requirements.

21 (c) The pool has the sole discretion to determine that an
22 individual does not meet the eligibility requirements for coverage.

23 (d) An individual may maintain pool coverage for the period
24 the individual is satisfying a preexisting waiting period under
25 another health benefit plan or health benefit arrangement intended
26 to replace the pool coverage. (V.T.I.C. Art. 3.77, Secs. 10(d),
27 (f), (g).)

28 Source Law

29 (d) A person may maintain pool coverage for the
30 period of time the person is satisfying a preexisting
31 waiting period under another health insurance policy
32 or insurance arrangement intended to replace the pool
33 policy.

34 (f) Pool coverage shall cease:

35 (1) on the date a person is no longer a
36 resident of this state, except for a child who is a
37 student under 25 years of age and who is financially
38 dependent upon the parent, a child for whom a person

1 may be obligated to pay child support, or a child of
2 any age who is disabled and dependent upon the parent;

3 (2) on the date a person requests coverage
4 to end;

5 (3) upon the death of the covered person;

6 (4) on the date state law requires
7 cancellation of the policy;

8 (5) at the option of the pool, 30 days
9 after the pool sends to the person any inquiry
10 concerning the person's eligibility, including an
11 inquiry concerning the person's residence, to which
12 the person does not reply;

13 (6) on the 31st day after the day on which
14 a premium payment for pool coverage becomes due if the
15 payment is not made before that date; or

16 (7) at such time as the person ceases to
17 meet the eligibility requirements of this section.

18 (g) Coverage of a person who ceases to meet the
19 eligibility requirements of this section shall be
20 terminated on the earlier of the premium due date that
21 follows the date the pool determines the person does
22 not meet the eligibility requirements or the first day
23 of the month that follows the month in which the pool
24 determines the person does not meet the eligibility
25 requirements. The pool has the sole discretion to
26 determine that a person does not meet the eligibility
27 requirements.

28 Revisor's Note

29 Section 10(f)(1), V.T.I.C. Article 3.77, refers
30 to a person who ceases to be "a resident of this
31 state." Section 2(17), V.T.I.C. Article 3.77,
32 provides the definition of "resident" for the purposes
33 of that article, and that provision is revised in
34 Section 1506.152. Under that provision, to qualify as
35 a resident under V.T.I.C. Article 3.77 an individual
36 must be legally domiciled in this state. The revised
37 law in this section is drafted accordingly.

38 Revised Law

39 Sec. 1506.159. PROHIBITION ON ARRANGEMENT OR ATTEMPTED
40 ARRANGEMENT OF CERTAIN POOL COVERAGE; PENALTY. (a) A health
41 benefit plan issuer, agent, third-party administrator, or other
42 person authorized or licensed under this code may not arrange or
43 assist in, or attempt to arrange or assist in, the application for
44 coverage from or placement in the pool of an individual who is not
45 eligible under Section 1506.153(7) for coverage from the pool for
46 the purpose of separating the person from health benefit plan
47 coverage offered or provided in connection with employment that

1 would be available to the person as an employee or a dependent of an
2 employee.

3 (b) A violation of this section is an unfair method of
4 competition and an unfair or deceptive act or practice under
5 Chapter 541. (V.T.I.C. Art. 3.77, Sec. 10(h) (part).)

6 Source Law

7 (h) . . . An insurer, agent, third party
8 administrator, or other person licensed under this
9 code may not arrange or assist in or attempt to arrange
10 or assist in the application for pool coverage by, or
11 placement in the pool of a person who is ineligible
12 under this subsection for the purpose of separating
13 the person from health insurance benefits offered or
14 provided in connection with employment that would be
15 available to the person as an employee or dependent of
16 an employee. A violation of this section is an unfair
17 method of competition and an unfair or deceptive act or
18 practice under Article 21.21 of this code.

19 Revisor's Note

20 Section 10(h), V.T.I.C. Article 3.77, refers to
21 certain persons "licensed under this code." For
22 consistency with other provisions of this code and
23 because some of the persons listed would hold a
24 certificate of authority under this code, the revised
25 law refers to persons "authorized or licensed" under
26 this code.

27 [Sections 1506.160-1506.200 reserved for expansion]

28 SUBCHAPTER E. OPERATION OF POOL

29 Revised Law

30 Sec. 1506.201. PLAN OF OPERATION. (a) Operation and
31 management of the pool is governed by a plan of operation. The plan
32 of operation includes the articles, bylaws, and operating rules of
33 the pool that are adopted by the board.

34 (b) The plan of operation must ensure the fair, reasonable,
35 and equitable administration of the pool.

36 (c) In addition to complying with the other requirements of
37 this chapter, the plan of operation must include procedures for:

38 (1) operation of the pool;

39 (2) selection of an administrator as provided by

1 Section 1506.202;

2 (3) creation of a fund, under management of the board,
3 for administrative expenses;

4 (4) handling, accounting, and auditing of money and
5 other assets of the pool;

6 (5) development and implementation of a program to:

7 (A) publicize the existence of the pool, the
8 eligibility requirements for coverage under the pool, and
9 enrollment procedures; and

10 (B) foster public awareness of the pool;

11 (6) creation of a grievance committee to review
12 complaints presented by applicants for coverage from the pool and
13 individuals who are covered by the pool; and

14 (7) other matters as may be necessary and proper for
15 the execution of the board's powers, duties, and obligations under
16 this chapter.

17 (d) The board shall amend the plan of operation as necessary
18 to carry out this chapter. An amendment to the plan of operation
19 must be approved by the commissioner before it becomes a part of the
20 plan. (V.T.I.C. Art. 3.77, Secs. 2(15), 5(a) (part), (b), (f).)

21 Source Law

22 [Sec. 2]

23 (15) "Plan of operation" means the plan of
24 operation of the pool and includes the articles,
25 bylaws, and operating rules of the pool that are
26 adopted by the board under Section 5 of this article.

27 Sec. 5. (a) . . . a plan of operation for the
28 pool that will assure the fair, reasonable, and
29 equitable administration of the pool.

30 (b) In addition to the other requirements of
31 this article, the plan of operation must include
32 procedures for:

33 (1) operation of the pool;

34 (2) selecting an administrator as provided
35 under Section 7 of this article;

36 (3) creating a fund, under management of
37 the board, for administrative expenses;

38 (4) handling, accounting, and auditing of
39 money and other assets of the pool;

40 (5) developing and implementing a program
41 to publicize the existence of the pool, the
42 eligibility requirements for coverage under the pool,
43 enrollment procedures, and to foster public awareness
44 of the plan;

45 (6) creation of a grievance committee to

1 review complaints presented by applicants for coverage
2 from the pool and insureds who receive coverage from
3 the pool; and

4 (7) other matters as may be necessary and
5 proper for the execution of the board's powers, duties,
6 and obligations under this article.

7 (f) The board shall amend the plan of operation
8 as necessary to carry out this article. Amendments to
9 the plan of operation must be approved by the
10 commissioner before they become part of the plan.

11 Revisor's Note

12 Section 5(a), in part, and Sections 5(c), (d),
13 and (e), V.T.I.C. Article 3.77, relate to the initial
14 adoption of the plan of operation for the pool. Those
15 provisions are omitted from the revised law as
16 executed. The omitted law reads:

17 Sec. 5. (a) The pool's initial board
18 shall submit to the commissioner [a plan of
19 operation for the pool]

20 (c) After notice and hearing, the
21 commissioner shall approve the plan of
22 operation if it is determined that the plan
23 is suitable to assure the fair, reasonable,
24 and equitable administration of the pool.

25 (d) The plan of operation takes
26 effect on the date it is approved by
27 commissioner order.

28 (e) If the initial board fails to
29 submit a suitable plan of operation before
30 the 180th day following the appointment of
31 the initial board, the commissioner, after
32 notice and hearing, may adopt all necessary
33 and reasonable rules to provide a plan for
34 the pool. The rules adopted under this
35 subsection shall continue in effect until
36 the initial board submits, and the
37 commissioner approves, a plan of operation
38 under this section.

39 Revised Law

40 Sec. 1506.202. POOL ADMINISTRATOR. (a) The board may
41 select one or more health benefit plan issuers or a third-party
42 administrator authorized by the department to administer the pool.
43 The selection must be made under a competitive bidding process in
44 accordance with the plan of operation.

45 (b) The board shall establish criteria for evaluating the
46 bids submitted under this section. The criteria must include:

47 (1) the bidder's proven ability to handle individual
48 health benefit plans;

1 (2) the bidder's efficiency of claims paying
2 procedures;

3 (3) an estimate of total charges for administering the
4 pool;

5 (4) the bidder's ability to administer the pool in a
6 cost-efficient manner; and

7 (5) the bidder's financial condition and stability.
8 (V.T.I.C. Art. 3.77, Secs. 7(a), (b).)

9 Source Law

10 Sec. 7. (a) After completing a competitive
11 bidding process as provided by the plan of operation,
12 the board may select one or more insurers or a third
13 party administrator certified by the department to
14 administer the pool.

15 (b) The board shall establish criteria for
16 evaluating the bids submitted. The criteria must
17 include:

18 (1) an insurer's or third party
19 administrator's proven ability to handle individual
20 accident and health insurance;

21 (2) the efficiency of an insurer's or third
22 party administrator's claims paying procedures;

23 (3) an estimate of total charges for
24 administering the pool;

25 (4) an insurer's or third party
26 administrator's ability to administer the pool in a
27 cost-efficient manner; and

28 (5) the financial condition and stability
29 of the insurer or third party administrator.

30 Revisor's Note

31 Section 7(a), V.T.I.C. Article 3.77, refers to
32 certain persons "certified" to administer the pool.
33 For consistency with other provisions of this code,
34 the revised law substitutes "authorized" for
35 "certified."

36 Revised Law

37 Sec. 1506.203. ADMINISTRATOR'S TERM; SUCCEEDING TERM. (a)
38 A person selected as a pool administrator serves in that capacity
39 for a three-year term beginning on the date the board issues its
40 order making the selection.

41 (b) Not later than one year before the expiration of a pool
42 administrator's term, the board shall invite all health benefit
43 plan issuers, including the pool administrator, to submit bids to

1 serve as a pool administrator for the succeeding administration
2 period. The selection of the succeeding pool administrator must be
3 made not later than the sixth calendar month preceding the month in
4 which the pool administrator's term expires. (V.T.I.C. Art. 3.77,
5 Secs. 7(c), (d).)

6 Source Law

7 (c) An insurer or third party administrator
8 selected as an administering insurer or third party
9 administrator to administer the pool under this
10 section shall serve for a term of three years from the
11 date on which the board issues its order formally
12 making the selection.

13 (d) Not later than one year before the
14 expiration of an administering insurer's or third
15 party administrator's term, the board shall invite all
16 insurers, including the administering insurer or third
17 party administrator, to submit bids to serve for the
18 succeeding three-year administration period.
19 Selection of the succeeding administering insurer or
20 third party administrator must be made not later than
21 the sixth calendar month preceding the month in which
22 the administering insurer's or third party
23 administrator's term expires.

24 Revised Law

25 Sec. 1506.204. ADMINISTRATOR'S FUNCTIONS. (a) A pool
26 administrator shall perform the functions relating to the pool that
27 are assigned to the administrator.

28 (b) The assigned functions may include:

29 (1) performing eligibility and administrative claims
30 payment functions for the pool;

31 (2) establishing a billing procedure for collection of
32 premiums from individuals covered by the pool;

33 (3) performing functions necessary to ensure timely
34 payment of benefits to individuals covered by the pool, including:

35 (A) providing information relating to the proper
36 manner of submitting a claim for benefits to the pool and
37 distributing claim forms; and

38 (B) evaluating the eligibility of each claim for
39 payment by the pool;

40 (4) submitting regular reports to the board relating
41 to the operation of the pool; and

42 (5) determining after each calendar year the net

1 written and earned premiums, expenses of administration, and paid
2 and incurred losses of the pool for that calendar year and reporting
3 that information to the board and the commissioner.

4 (c) The board shall determine the form, content, and time of
5 submission of the reports required under Subsection (b)(4).

6 (d) The commissioner shall prescribe the forms to be used to
7 report the information under Subsection (b)(5).

8 (e) The board shall determine the times at which a pool
9 administrator is to perform the billing functions for the pool.
10 (V.T.I.C. Art. 3.77, Secs. 7(e), (g), (h).)

11 Source Law

12 (e) The administering insurer or third party
13 administrator shall perform such functions relating to
14 the pool as may be assigned to it, including:

15 (1) perform eligibility and
16 administrative claims payment functions for the pool;

17 (2) establish a billing procedure for
18 collection of premiums from persons insured by the
19 pool;

20 (3) perform functions necessary to assure
21 timely payment of benefits to persons covered under
22 the pool, including:

23 (A) providing information relating
24 to the proper manner of submitting a claim for benefits
25 to the pool and distributing claim forms; and

26 (B) evaluating the eligibility of
27 each claim for payment by the pool;

28 (4) submit regular reports to the board
29 relating to the operation of the pool; and

30 (5) determine after the close of each
31 calendar year the net written and earned premiums,
32 expense of administration, and paid and incurred
33 losses of the pool for that calendar year and report
34 this information to the board and the commissioner on
35 forms prescribed by the commissioner.

36 (g) The board shall determine the form and
37 content of the report required by Subsection (e)(4) of
38 this section and the time at which reports must be
39 made.

40 (h) The board shall determine the times at which
41 billing for the pool will be done by the administering
42 insurer or third party administrator.

43 Revised Law

44 Sec. 1506.205. PAYMENTS TO ADMINISTRATOR. (a) The pool
45 shall pay a pool administrator for the administrator's expenses
46 incurred in performing duties and functions as provided by the plan
47 of operation.

48 (b) Except as provided by Subsection (c), the total amount

1 of administrative costs and fees paid in a calendar year to all pool
2 administrators may not exceed 12.5 percent of the gross premium
3 receipts of the pool for the calendar year.

4 (c) The commissioner may approve payment of a higher amount,
5 not to exceed 15 percent of the gross premium receipts of the pool
6 for the calendar year, if the commissioner determines that the
7 higher amount is necessary to pay the administrative costs and fees
8 of the pool. (V.T.I.C. Art. 3.77, Sec. 7(f).)

9 Source Law

10 (f) The pool shall pay an administering insurer
11 or third party administrator for its expenses incurred
12 in performing its duties and functions as provided by
13 the plan of operation. Except as otherwise provided by
14 this subsection, the total amount of administrative
15 costs and fees paid in a calendar year to all
16 administering insurers or a third party administrator
17 may not exceed 12.5 percent of the gross premium
18 receipts of the pool for the calendar year. The
19 commissioner may approve payment of a higher amount,
20 not to exceed 15 percent of the gross premium receipts
21 of the pool for the calendar year, if the commissioner
22 determines that the higher amount is necessary to pay
23 the administrative costs and fees of the pool.

24 [Sections 1506.206-1506.250 reserved for expansion]

25 SUBCHAPTER F. ASSESSMENTS FOR OPERATION OF POOL

26 Revised Law

27 Sec. 1506.251. INTERIM ASSESSMENTS. (a) The board may
28 assess health benefit plan issuers, including making advance
29 interim assessments, as reasonable and necessary for the pool's
30 organizational and interim operating expenses.

31 (b) The board shall credit an interim assessment as an
32 offset against any regular assessment that is due after the end of
33 the fiscal year. (V.T.I.C. Art. 3.77, Sec. 13(a).)

34 Source Law

35 Sec. 13. (a) The board may assess insurers and
36 make advance interim assessments as reasonable and
37 necessary for the plan's organizational and interim
38 operating expenses. Any interim assessment shall be
39 credited as offsets against any regular assessments
40 due following the close of the fiscal year.

41 Revised Law

42 Sec. 1506.252. DETERMINATION OF NET LOSS. (a) After the
43 end of each fiscal year, the board shall determine for the preceding

1 calendar year any net loss of the pool, including administrative
2 expenses and incurred losses, and report the net loss to the
3 commissioner.

4 (b) In determining the net loss, the board shall take into
5 account investment income and other appropriate gains and losses.
6 (V.T.I.C. Art. 3.77, Sec. 13(c) (part).)

7 Source Law

8 (c) After the end of each fiscal year, the board
9 shall determine and report to the commissioner the net
10 loss, if any, of the pool for the previous calendar
11 year, including administrative expenses and incurred
12 losses for the year, taking into account investment
13 income and other appropriate gains and losses. . . .

14 Revised Law

15 Sec. 1506.253. ASSESSMENTS TO COVER NET LOSSES. (a) The
16 board shall recover any net loss of the pool by assessing each
17 health benefit plan issuer an amount determined annually by the
18 board based on information in annual statements and other reports
19 required by and filed with the board.

20 (b) The amount of a health benefit plan issuer's assessment
21 is computed by multiplying the total amount required to be assessed
22 against all health benefit plan issuers by a number computed by
23 dividing:

24 (1) the gross premiums collected by the issuer for
25 health benefit plans in this state during the preceding calendar
26 year; by

27 (2) the gross premiums collected by all issuers for
28 health benefit plans in this state during the preceding calendar
29 year.

30 (c) For purposes of Subsection (b), gross health benefit
31 plan premiums do not include Medicare supplement benefit plan
32 premiums subject to Chapter 1652 or small employer health benefit
33 plan premiums subject to Subchapters A-H, Chapter 1501. (V.T.I.C.
34 Art. 3.77, Secs. 13(c) (part), (d) (part).)

35 Source Law

36 (c) . . . Any net loss for the year shall be
37 recouped by assessments on insurers. Each insurer's

1 assessment shall be determined annually by the board
2 based on annual statements and other reports required
3 by the board and filed with the board.

4 (d) The assessment imposed against each insurer
5 shall be in an amount that is equal to the ratio of the
6 gross premiums collected by the insurer for health
7 insurance in this state during the preceding calendar
8 year, except for Medicare supplement premiums subject
9 to Article 3.74 and small group health insurance
10 premiums subject to Articles 26.01 through 26.76, to
11 the gross premiums collected by all insurers for
12 health insurance, except for Medicare supplement
13 premiums subject to Article 3.74 and small group
14 health insurance premiums subject to Articles 26.01
15 through 26.76, in this state during the preceding
16 calendar year. . . .

17 Revisor's Note

18 Section 13(d), V.T.I.C. Article 3.77, refers to
19 "small group health insurance premiums subject to
20 Articles 26.01 through 26.76." V.T.I.C. Chapter 26
21 refers to "small employer health benefit plans" rather
22 than "small group health insurance," and the revised
23 law is drafted accordingly.

24 Revised Law

25 Sec. 1506.254. ASSESSMENT DUE DATE; INTEREST. (a) An
26 assessment is due on the date specified by the board that is not
27 earlier than the 30th day after the date written notice of the
28 assessment is transmitted to the health benefit plan issuer.

29 (b) Interest accrues on the unpaid amount of an assessment
30 at a rate equal to the prime lending rate, as published in the most
31 recent issue of the Wall Street Journal and determined as of the
32 date the assessment becomes delinquent, plus three percent.
33 (V.T.I.C. Art. 3.77, Sec. 13(d) (part).)

34 Source Law

35 (d) . . . An assessment is due on a date
36 specified by the board that may not be earlier than the
37 30th day after the date on which prior written notice
38 of the assessment due is transmitted to the insurer.
39 Interest accrues on the unpaid amount at a rate equal
40 to the prime lending rate, as stated in the most recent
41 issue of the Wall Street Journal, plus three percent,
42 determined as of the date such assessment is
43 delinquent.

44 Revised Law

45 Sec. 1506.255. ABATEMENT OR DEFERMENT OF ASSESSMENT. (a) A
46 health benefit plan issuer may petition the commissioner for an

1 abatement or deferment of all or part of an assessment imposed by
2 the board. The commissioner may abate or defer all or part of the
3 assessment if the commissioner determines that payment of the
4 assessment would endanger the ability of the health benefit plan
5 issuer to fulfill its contractual obligations.

6 (b) If all or part of an assessment against a health benefit
7 plan issuer is abated or deferred, the amount of the abatement or
8 deferment shall be assessed against the other health benefit plan
9 issuers in a manner consistent with the method for computing
10 assessments under this subchapter.

11 (c) A health benefit plan issuer receiving an abatement or
12 deferment under this section remains liable to the pool for the
13 deficiency. (V.T.I.C. Art. 3.77, Sec. 13(e).)

14 Source Law

15 (e) An insurer may petition the commissioner for
16 an abatement or deferment of all or part of an
17 assessment imposed by the board. The commissioner may
18 abate or defer all or part of the assessment if the
19 commissioner determines that payment of the assessment
20 would endanger the ability of the insurer to fulfill
21 its contractual obligations. If all or part of an
22 assessment against an insurer is abated or deferred,
23 the amount by which the assessment is abated or
24 deferred shall be assessed against the other insurers
25 in a manner consistent with the basis for computing
26 assessments under this section. An insurer receiving
27 an abatement or deferment under this subsection
28 remains liable to the pool for the deficiency.

29 Revised Law

30 Sec. 1506.256. USE OF EXCESS FROM ASSESSMENTS. (a) In
31 this section, "future losses" includes reserves for claims incurred
32 but not reported.

33 (b) If the total amount of the assessments exceeds the
34 pool's actual losses and administrative expenses, the board shall
35 deposit the excess in an interest-bearing account and shall use
36 money in that account to offset future losses or to reduce future
37 assessments. (V.T.I.C. Art. 3.77, Sec. 13(b).)

38 Source Law

39 (b) If assessments exceed the pool's actual
40 losses and administrative expenses, the excess shall
41 be held in an interest-bearing account and used by the
42 board to offset future losses or to reduce future

assessments. As used in this section, future losses includes reserves for incurred but not reported claims.

Revised Law

Sec. 1506.257. COLLECTION OF ASSESSMENTS. The pool may recover or collect assessments made under this subchapter. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:
 (11) recover or collect assessments imposed under Section 13 of this article;
 . . .

Revised Law

Sec. 1506.258. PROCEDURES, CRITERIA, AND FORMS. The commissioner by rule shall provide the procedures, criteria, and forms necessary to implement, collect, and deposit assessments under this subchapter. (V.T.I.C. Art. 3.77, Sec. 8 (part).)

Source Law

Sec. 8. . . . The commissioner by rule shall provide the procedures, criteria, and forms necessary to implement, collect, and deposit assessments made and collected under Section 13.

[Chapters 1507-1550 reserved for expansion]

SUBTITLE I. SPECIALIZED COVERAGES

CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS

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[Sections 1651.007-1651.050 reserved for expansion]

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2 CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS

3 SUBCHAPTER A. GENERAL PROVISIONS

4 Revised Law

5 Sec. 1651.001. APPLICABILITY OF CHAPTER. (a)
6 Notwithstanding Section 101.053(b)(5) and subject to Subsection
7 (b), this chapter applies only to:

8 (1) an individual long-term care benefit plan that is
9 delivered or issued for delivery in this state;

10 (2) a group long-term care benefit plan that is:

11 (A) delivered or issued for delivery in this
12 state; and

13 (B) issued to an eligible group as described by
14 Subchapter B, Chapter 1251;

15 (3) a certificate issued under a group long-term care
16 benefit plan issued to an eligible group as described by Subchapter
17 B, Chapter 1251, if the certificate is delivered or issued for
18 delivery in this state, regardless of the place where the plan is
19 delivered or issued for delivery; and

20 (4) an evidence of coverage delivered or issued for
21 delivery in this state for long-term care.

22 (b) This chapter applies only to a policy, certificate, or
23 evidence of coverage that is issued by:

24 (1) a capital stock insurance company, including a
25 life, health and accident, or general casualty insurance company;

26 (2) a mutual life insurance company;

27 (3) a mutual assessment life insurance company,
28 including a statewide mutual assessment corporation, local mutual
29 aid association, and burial association;

30 (4) a mutual or mutual assessment association,
31 including an association subject to Section 887.101;

32 (5) a mutual insurance company other than a life
33 insurance company;

34 (6) a mutual or natural premium life or casualty

1 insurance company;

2 (7) a fraternal benefit society;

3 (8) a Lloyd's plan insurer;

4 (9) a reciprocal or interinsurance exchange;

5 (10) a nonprofit medical, hospital, or dental service
6 corporation, including a company subject to Chapter 842;

7 (11) a stipulated premium company;

8 (12) a health maintenance organization under Chapter
9 843; or

10 (13) another insurer required to be licensed by the
11 department. (V.T.I.C. Art. 3.70-12, Secs. 1(a), (b), 2(2), (3).)

12 Source Law

13 Art. 3.70-12

14 Sec. 1. (a) Notwithstanding Section 2(b)(5) of
15 Article 1.14-1 of this code, this article applies to
16 and governs individual and group long-term care
17 insurance policies delivered or issued for delivery in
18 this state and certificates issued under group
19 long-term care insurance policies that have been
20 delivered or issued for delivery in this state, if
21 those policies or certificates are issued by:

22 (1) capital stock companies, including but
23 not limited to life, health and accident, and general
24 casualty companies;

25 (2) mutual life insurance companies;

26 (3) mutual assessment life insurance
27 companies, including statewide mutual assessment
28 corporations, local mutual aids, and burial
29 associations;

30 (4) mutual and mutual assessment
31 associations of all kinds and types, including
32 associations subject to Article 14.17 of this code;

33 (5) mutual insurance companies other than
34 life companies;

35 (6) mutual or natural premium life or
36 casualty insurance companies;

37 (7) fraternal benefit societies;

38 (8) Lloyd's plan insurers;

39 (9) reciprocal or inter-insurance
40 exchanges;

41 (10) nonprofit hospital, medical or dental
42 service corporations, including companies subject to
43 Chapter 20 of this code;

44 (11) stipulated premium insurance
45 companies; or

46 (12) any other insurer which by law is
47 required to be licensed by the Texas Department of
48 Insurance.

49 (b) This article shall apply to evidences of
50 coverage delivered or issued for delivery for
51 long-term care in this state by health maintenance
52 organizations under the Texas Health Maintenance
53 Organization Act (Chapter 20A, Vernon's Texas
54 Insurance Code).

1 Sec. 2. In this article:

2 (2) "Certificate" means any certificate
3 issued under a group long-term insurance policy, which
4 certificate has been delivered or issued for delivery
5 in this state, regardless of the place where the policy
6 was delivered or issued for delivery.

7 (3) "Group long-term care insurance" means
8 any long-term care insurance policy or certificate of
9 group long-term care insurance which is delivered or
10 issued for delivery in this state and issued to an
11 eligible group as defined by Section 1(a), Article
12 3.51-6 of this code.

13 Revisor's Note

14 (1) Section 1(a), V.T.I.C. Article 3.70-12,
15 states that this article "applies to and governs"
16 certain long-term care insurance policies. The
17 revised law omits "governs" because, in context,
18 "governs" is included in the meaning of "applies to."

19 (2) Sections 1(a) and 2(2), V.T.I.C. Article
20 3.70-12, refer to long-term care "insurance policies,"
21 and Section 2(3), V.T.I.C. Article 3.70-12, defines
22 group long-term care "insurance." The revised law
23 substitutes "benefit plan" for the references to
24 insurance policies and insurance because V.T.I.C.
25 Article 3.70-12, revised as this chapter, applies to
26 evidences of coverage for long-term care issued by
27 health maintenance organizations. Health maintenance
28 organizations provide health benefit coverage, but the
29 organizations are not insurers. Consequently,
30 "benefit plan" is a more accurate term than "insurance
31 policy" or "insurance." The substitution of "benefit
32 plan," as well as any comparable change necessary to
33 ensure consistent terminology, is made throughout this
34 chapter.

35 (3) Section 1(a)(1), V.T.I.C. Article 3.70-12,
36 refers to "including but not limited to." "But not
37 limited to" is omitted as unnecessary because Section
38 311.005(13), Government Code (Code Construction Act),
39 and Section 312.011(19), Government Code, provide that

1 "includes" and "including" are terms of enlargement
2 and not of limitation and do not create a presumption
3 that components not expressed are excluded.

4 Revised Law

5 Sec. 1651.002. EXEMPTIONS. This chapter does not apply to:

6 (1) a certificate that is delivered or issued for
7 delivery in this state under a single employer or labor union group
8 policy that is delivered or issued for delivery outside this state;
9 or

10 (2) a benefit plan that is not advertised, marketed,
11 or offered as a long-term care benefit plan or nursing home benefit
12 plan. (V.T.I.C. Art. 3.70-12, Secs. 1(d), (e).)

13 Source Law

14 (d) This article does not apply to certificates
15 that are delivered or issued for delivery in this state
16 under a single employer or labor union group policy
17 that is delivered or issued for delivery outside this
18 state.

19 (e) This article does not apply to a policy that
20 is not advertised, marketed, or offered as long-term
21 care insurance or nursing home insurance.

22 Revised Law

23 Sec. 1651.003. LONG-TERM CARE BENEFIT PLAN DEFINED. (a) In
24 this chapter, "long-term care benefit plan" means an insurance
25 policy or group certificate, or rider to the policy or certificate,
26 or evidence of coverage issued by a health maintenance organization
27 subject to Chapter 843, that is advertised or marketed as
28 providing, or offered or designed to provide, coverage for not less
29 than 12 consecutive months for each covered individual on an
30 expense-incurred, indemnity, prepaid, or other basis for one or
31 more necessary or medically necessary diagnostic, preventive,
32 therapeutic, rehabilitative, maintenance, or personal care
33 services provided in a setting other than an acute care unit of a
34 hospital.

35 (b) The term includes a plan or rider, other than a group or
36 individual annuity or life insurance policy, that provides for
37 payment of benefits based on cognitive impairment or the loss of

1 functional capacity.

2 (c) The term does not include an insurance policy, group
3 certificate, or evidence of coverage that is offered primarily to
4 provide:

5 (1) basic Medicare supplement coverage, basic
6 hospital expense coverage, basic medical-surgical expense
7 coverage, hospital confinement indemnity coverage, major medical
8 expense coverage, disability income protection coverage,
9 accident-only coverage, specified disease or specified accident
10 coverage, or limited benefit health coverage; or

11 (2) basic or single health care services. (V.T.I.C.
12 Art. 3.70-12, Sec. 2(4).)

13 Source Law

14 Sec. 2. In this article:

15 (4) "Long-term care insurance policy"
16 means any insurance policy, group certificate, or
17 rider to such policy or certificate, or evidence of
18 coverage issued by a health maintenance organization
19 subject to the Texas Health Maintenance Organization
20 Act (Chapter 20A, Vernon's Texas Insurance Code),
21 which policy, certificate, rider or evidence of
22 coverage is advertised, marketed, offered, or designed
23 to provide coverage for not less than 12 consecutive
24 months for each covered person on an expense-incurred,
25 indemnity, prepaid, or other basis for one or more
26 necessary or medically necessary diagnostic,
27 preventive, therapeutic, rehabilitative, maintenance,
28 or personal care services, provided in a setting other
29 than an acute care unit of a hospital. The term also
30 includes a policy or rider, other than a group or
31 individual annuity or life insurance policy, that
32 provides for payment of benefits based on cognitive
33 impairment or the loss of functional capacity. The
34 term "long-term care insurance" shall not include any
35 insurance policy or group certificate which is offered
36 primarily to provide basic medicare supplement
37 coverage, basic hospital expense coverage, basic
38 medical-surgical expense coverage, hospital
39 confinement indemnity coverage, major medical expense
40 coverage, disability income protection coverage,
41 accident only coverage, specified disease or specified
42 accident coverage, limited benefit health coverage, or
43 basic or single health care services.

44 Revisor's Note

45 Section 2(4), V.T.I.C. Article 3.70-12, in the
46 third sentence, excludes "any insurance policy or
47 group certificate" from the scope of the defined term
48 if the policy or certificate provides certain

1 specified coverage. The revised law adds a reference
2 to "evidence of coverage" to the exclusionary language
3 for clarity and consistency with the remainder of
4 Section 2(4). The first sentence of Section 2(4)
5 provides that "evidence of coverage" is included in
6 the scope of the defined term in some instances.
7 Consequently, in context, it is clear that "evidence
8 of coverage" should be excluded in the instances
9 described in the third sentence of Section 2(4).

10 Revised Law

11 Sec. 1651.004. RULES. (a) In addition to other rules
12 required or authorized by this chapter, the department may adopt
13 reasonable rules that are necessary and proper to carry out this
14 chapter.

15 (b) Rules adopted under this section must include
16 requirements no less favorable than the minimum standards for
17 long-term care benefit plans adopted in any model laws or
18 regulations relating to minimum standards for benefits for
19 long-term care benefit plans and in accordance with all applicable
20 federal law. (V.T.I.C. Art. 3.70-12, Sec. 7.)

21 Source Law

22 Sec. 7. In addition to other rules required or
23 authorized by this article, the State Board of
24 Insurance may adopt reasonable rules that are
25 necessary and proper to carry out this article. Any
26 rules so adopted shall include requirements no less
27 favorable than minimum standards for long-term care
28 insurance adopted in any model laws or regulations
29 relating to minimum standards for benefits for
30 long-term care insurance and in accordance with all
31 applicable federal law.

32 Revisor's Note

33 Section 7, V.T.I.C. Article 3.70-12, refers to
34 "the State Board of Insurance." Chapter 685, Acts of
35 the 73rd Legislature, Regular Session, 1993, abolished
36 the board and transferred its functions to the
37 commissioner of insurance and the Texas Department of
38 Insurance. Throughout this chapter, references to the

board have been changed appropriately.

Revised Law

Sec. 1651.005. CONSTRUCTION OF CHAPTER. This chapter may not be construed to enlarge the powers of an entity listed in Section 1651.001. (V.T.I.C. Art. 3.70-12, Sec. 1(c).)

Source Law

(c) This article may not be construed to enlarge the powers of any of the enumerated companies.

Revised Law

Sec. 1651.006. CONFLICTS WITH OTHER PROVISIONS. This chapter prevails to the extent of any conflict with another provision of this code. (V.T.I.C. Art. 3.70-12, Sec. 6 (part).)

Source Law

Sec. 6. . . . in the event of any conflict between a provision of this article and any other provisions of this code, the provision of this article controls to the extent of the conflict. . . .

Revisor's Note

(1) Section 6, V.T.I.C. Article 3.70-12, refers to the cumulative effect of that article. An accepted general principle of statutory construction requires a statute to be given cumulative effect with other statutes unless it provides otherwise or unless the statutes are in conflict. The general principle applies to this revision. The omitted law reads:

Sec. 6. This article is cumulative of all other law, but

(2) The portion of Section 6, V.T.I.C. Article 3.70-12, that provides that the article is severable is omitted because that provision duplicates Section 311.032, Government Code (Code Construction Act), applicable to the revised law, and Section 312.013, Government Code. These provisions state that a provision of a statute is severable from each other provision of the statute that can be given effect. The omitted law reads:

1 Sec. 6. . . . If any provision of
2 this article or the application of any
3 provision of this article to any person or
4 circumstance is for any reason held to be
5 invalid, the remainder of this article and
6 the application of that provision to other
7 persons or circumstances shall not be
8 affected by the invalidity.

9 [Sections 1651.007-1651.050 reserved for expansion]

10 SUBCHAPTER B. BENEFIT PLAN STANDARDS

11 Revised Law

12 Sec. 1651.051. MINIMUM STANDARDS. (a) The commissioner by
13 rule shall establish:

14 (1) specific standards for provisions of long-term
15 care benefit plans; and

16 (2) standards for full and fair disclosure setting
17 forth the manner, content, and required disclosures for the
18 marketing and sale of those benefit plans.

19 (b) The standards are in addition to and must be in
20 accordance with:

21 (1) applicable laws of this state, including Chapter
22 1201;

23 (2) applicable federal law; and

24 (3) any rules, regulations, and standards required by
25 federal law.

26 (c) The standards must address:

27 (1) terms of renewability;

28 (2) initial and subsequent conditions of eligibility;

29 (3) nonduplication of coverage;

30 (4) coverage of dependents;

31 (5) coverage of parents of the insured or enrollee and
32 parents of the spouse of the insured or enrollee;

33 (6) preexisting conditions;

34 (7) termination of insurance;

35 (8) continuation or conversion;

36 (9) probationary periods;

37 (10) benefit limitations, exceptions, and reductions;

38 (11) elimination periods;

1 (12) requirements for replacement;
2 (13) recurrent conditions;
3 (14) definitions of terms; and
4 (15) inflation protection.
5 (d) The standards may:
6 (1) establish standard claim forms;
7 (2) establish standard benefits for:
8 (A) skilled nursing care;
9 (B) intermediate nursing care;
10 (C) custodial care; and
11 (D) home health care;
12 (3) require coverage for skilled nursing care,
13 intermediate nursing care, and custodial care to facilitate
14 comparison among long-term care products;
15 (4) require long-term care benefit plan issuers to
16 offer coverage for home health care benefits;
17 (5) require that rates may not be increased for a
18 covered individual unless:
19 (A) the covered individual requests and receives
20 a change of benefits; or
21 (B) the increase applies to all members of the
22 class to which the individual has been assigned by the benefit plan
23 issuer; or
24 (6) require a benefit plan issuer to pay for a service
25 covered by the benefit plan that is provided by an institution
26 licensed to provide that service under Chapter 242, Health and
27 Safety Code.
28 (e) Rules adopted under this section must include
29 requirements no less favorable than the minimum standards of
30 benefits for long-term care benefit plans adopted in any model laws
31 or regulations relating to minimum standards for benefits for
32 long-term care benefit plans and required by federal law.
33 (V.T.I.C. Art. 3.70-12, Secs. 3(a), (b), (c), (d).)

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(b) The standards established under Subsection (a) of this section shall cover the following:

- (c) The standards established under Subsection (a) of this section may:

- (6) require an insurer to pay for services covered by the policy that are rendered by any institution licensed to provide those services under Chapter 242, Health and Safety Code.

Revisor's Note

- 1354

1 refers to the "applicable laws of this state,
2 including Subchapter G of Chapter 3" of the Insurance
3 Code. The majority of Subchapter G, Chapter 3,
4 Insurance Code, and the provisions primarily
5 applicable to long-term care benefit plans, are
6 revised as Chapter 1201 of this code. The revised law
7 is drafted accordingly.

8 (2) Section 3(b)(5), V.T.I.C. Article 3.70-12,
9 refers to "the insured." The revised law adds a
10 reference to an "enrollee" because this chapter
11 applies to a health maintenance organization that
12 provides long-term care coverage. "Enrollee" is the
13 proper term to refer to a person covered under a
14 benefit plan provided by a health maintenance
15 organization.

16 Revised Law

17 Sec. 1651.052. PREEXISTING CONDITIONS. (a) A long-term
18 care benefit plan may not contain a provision that denies coverage
19 for a claim for losses incurred more than six months after the
20 effective date of coverage for a preexisting condition.

21 (b) A long-term care benefit plan may not define a
22 preexisting condition more restrictively than as a condition for
23 which medical advice was given or treatment was recommended by or
24 received from a physician within six months before the effective
25 date of coverage.

26 (c) The commissioner by rule may:

27 (1) establish additional reasonable regulation of
28 preexisting conditions consistent with this section and Section
29 1651.051; and

30 (2) extend a limitation period specified in this
31 section as to a specific age group category in a specific benefit
32 plan form if the commissioner finds that the extension is in the
33 best interest of the public.

34 (d) Rules adopted under this section must comply with

1 Section 1651.051(e). (V.T.I.C. Art. 3.70-12, Secs. 3(d), (e).)

2 Source Law

3 (d) Any rules issued by the State Board of
4 Insurance under this section shall include
5 requirements no less favorable than the minimum
6 standards of benefits for long-term care insurance
7 adopted in any model laws or regulations relating to
8 minimum standards for benefits for long-term care
9 insurance and mandated by federal law.

10 (e) In addition to other provisions of this
11 section, a long-term care insurance policy or
12 certificate subject to this article may not contain a
13 provision which denies a claim for losses incurred
14 more than six months from the effective date of
15 coverage for a preexisting condition. A policy may not
16 define a preexisting condition more restrictively than
17 a condition for which medical advice was given or
18 treatment was recommended by or received from a
19 physician within six months before the effective date
20 of coverage. The State Board of Insurance by rule may
21 provide for additional reasonable regulation of
22 preexisting conditions consistent with this section.
23 That authority includes the authority to extend the
24 limitations periods set forth in this section as to
25 specific age group categories in specific policy
26 forms, based on the board's first finding that such an
27 extension is in the best interest of the public.

28 Revisor's Note

29 Section 3(e), V.T.I.C. Article 3.70-12, refers to
30 a long-term care "certificate." Throughout this
31 chapter, the revised law omits "certificate" as
32 unnecessary in this context because the term is
33 included in the meaning of "long-term care benefit
34 plan" as defined in Section 1651.003.

35 Revised Law

36 Sec. 1651.053. LOSS RATIO STANDARDS. (a) A long-term
37 care benefit plan must provide a benefit plan holder with benefits
38 that are reasonable in relation to the rates charged.

39 (b) The commissioner shall adopt reasonable rules to
40 establish minimum standards for loss ratios of long-term care
41 benefit plans on the basis of:

- 42 (1) incurred claims experience;
43 (2) earned premiums;
44 (3) the period for which rates are computed to provide
45 coverage;
46 (4) experienced and projected trends;

1 (5) concentration of experience within early benefit
2 plan duration;
3 (6) expected claim fluctuations;
4 (7) experience refunds;
5 (8) adjustments;
6 (9) dividends;
7 (10) renewability features;
8 (11) all relevant expense factors;
9 (12) interest;
10 (13) reserves;
11 (14) mix of business by risk classification; and
12 (15) product features otherwise affecting claims
13 experience.

14 (c) Annually, each entity providing a long-term care
15 benefit plan in this state shall:

16 (1) file its rates, rating schedule, and supporting
17 documentation to demonstrate compliance with the applicable loss
18 ratio standards of this state; and

19 (2) comply with any other filing requirement adopted
20 by the commissioner relating to loss ratios.

21 (d) Rules adopted under this section shall be no less
22 favorable to the holders of long-term care benefit plans than any
23 model laws, rules, and regulations adopted in connection with
24 minimum standards for benefits for long-term care benefit plans.

25 (V.T.I.C. Art. 3.70-12, Sec. 4.)

26 Source Law

27 Sec. 4. (a) Long-term care insurance policies
28 shall return to holders of the policies benefits that
29 are reasonable in relation to the premium charged. The
30 State Board of Insurance shall adopt reasonable rules
31 to establish minimum standards for loss ratios of
32 long-term care insurance policies on the basis of
33 incurred claims experience, earned premiums, the
34 period for which rates are computed to provide
35 coverage, experienced and projected trends,
36 concentration of experience within early policy
37 duration, expected claim fluctuation, experience
38 refunds, adjustments, dividends, renewability
39 features, all relevant expense factors, interest,
40 policy reserves, mix of business by risk
41 classification, and product features otherwise

1 affecting claims experience.

2 (b) Each entity providing long-term care
3 insurance in this state annually shall file its rates,
4 rating schedule, and supporting documentation
5 demonstrating that it is in compliance with the
6 applicable loss ratio standards of this state, as well
7 as any other filing requirements relating to loss
8 ratios promulgated under rules adopted by the State
9 Board of Insurance.

10 (c) The State Board of Insurance shall adopt
11 reasonable rules providing loss ratio standards
12 applicable to rates charged for long-term care
13 insurance policies. The rules adopted shall be no less
14 favorable to the holders of those policies than any
15 model laws, rules, and regulations adopted in
16 connection with minimum standards for benefits for
17 long-term care insurance.

18 Revised Law

19 Sec. 1651.054. NOTICE OF RIGHT TO REFUND. (a) In this
20 section, "applicant" means:

21 (1) in the case of an individual long-term care
22 benefit plan, the individual who seeks to contract for insurance or
23 other health benefits; and

24 (2) in the case of a group long-term care benefit plan,
25 the proposed certificate holder.

26 (b) A long-term care benefit plan must have a notice
27 prominently printed on the first page of or attached to the benefit
28 plan document.

29 (c) The notice must state in substance that, if the
30 applicant is not satisfied for any reason after examining the
31 benefit plan document, the applicant is entitled to:

32 (1) return the document not later than the 30th day
33 after the date of its delivery; and

34 (2) have any premium refunded.

35 (d) The long-term care benefit plan issuer shall pay in a
36 timely manner the refund directly to the individual or entity that
37 paid the premium. (V.T.I.C. Art. 3.70-12, Secs. 2(1), 5.)

38 Source Law

39 Sec. 2. In this article:

40 (1) "Applicant" means:

41 (A) in the case of an individual
42 long-term care insurance policy, the person who seeks
43 to contract for insurance or other health benefits;
44 and

45 (B) in the case of a group long-term
46 care insurance policy, the proposed certificate

holder.

Sec. 5. Each long-term care insurance policy or certificate must have a notice prominently printed on the first page of or attached to the policy or certificate stating in substance that the applicant has the right to return the policy or certificate within 30 days of the date of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. The entity issuing the policy or certificate shall pay in a timely manner a refund made under this section directly to the person or entity that remitted the premium.

Revised Law

Sec. 1651.055. RATE STABILIZATION. (a) The commissioner shall adopt rules to stabilize long-term care premium rates by:

(1) ensuring that:

(A) initial rates for long-term care benefit plan forms are adequate; and

(B) any rate schedule increases for long-term care benefit plans made after issuance of the plans are justified, adequate, and reasonable in relation to benefits provided to plan holders;

(2) requiring any appropriate plan terms;

(3) imposing penalties on insurers or other entities subject to this chapter that violate a rule adopted under this section; and

(4) protecting plan holders affected by a rate schedule increase.

(b) Except as provided by this subsection, the commissioner shall adopt rules under this section that are consistent with nationally recognized models relating to the stabilization of long-term care premium rates that existed on January 1, 2001. The commissioner may adopt rules consistent with any of those models as they are amended after January 1, 2001. The commissioner shall adopt rules under this subsection that:

(1) to the extent possible, contribute to the uniformity of state laws; and

(2) protect consumers.

(c) In adopting rules under this section, the commissioner

may exempt long-term care benefit plans from the requirements of Sections 1651.053(a), (b), and (d). (V.T.I.C. Art. 3.70-12, Sec. 5A.)

Source Law

Sec. 5A. (a) The commissioner shall adopt rules to stabilize long-term care insurance premium rates by:

- (1) ensuring that:
 - (A) initial rates for long-term care insurance policy forms are adequate; and
 - (B) any rate schedule increases for long-term care insurance policies made after issuance of the policies are justified, adequate, and reasonable in relation to benefits provided to policy or certificate holders;
- (2) requiring any appropriate policy terms;
- (3) imposing penalties on insurers or other entities subject to this article that violate a rule adopted under this section; and
- (4) protecting policy and certificate holders affected by a rate schedule increase.

(b) Except as provided by this subsection, the commissioner shall adopt rules under this section that are consistent with nationally recognized models relating to the stabilization of long-term care insurance premium rates that existed on January 1, 2001. The commissioner may adopt rules consistent with any of those models as they are amended after January 1, 2001. The commissioner shall adopt rules under this subsection that:

- (1) to the extent possible, contribute to the uniformity of state laws; and
- (2) protect consumers.

(c) In adopting rules under this section, the commissioner may exempt long-term care insurance policies from the requirements of Sections 4(a) and (c) of this article.

CHAPTER 1652. MEDICARE SUPPLEMENT BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

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8 [Sections 1652.059-1652.100 reserved for expansion]

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28 CHAPTER 1652. MEDICARE SUPPLEMENT BENEFIT PLANS

29 SUBCHAPTER A. GENERAL PROVISIONS

30 Revised Law

31 Sec. 1652.001. DEFINITIONS. In this chapter:

32 (1) "Applicant" means:

33 (A) an individual who seeks to contract for

34 insurance or other health benefits under an individual Medicare

1 supplement benefit plan; or

2 (B) the proposed certificate holder of a group
3 Medicare supplement benefit plan.

4 (2) "Approved regulatory program" means a state
5 regulatory program that complies with the requirements of Section
6 1882, Social Security Act (42 U.S.C. Section 1395ss).

7 (3) "Medicare" means the Health Insurance for the Aged
8 Act (42 U.S.C. Section 1395 et seq.), as amended. (V.T.I.C. Art.
9 3.74, Secs. 1(b)(1), (4); New.)

10 Source Law

11 (b) Definitions.

12 (1) "Applicant" means:

13 (A) in the case of an individual
14 medicare supplement policy, the person who seeks to
15 contract for insurance or other health benefits, and

16 (B) in the case of a group medicare
17 supplement policy, the proposed certificate holder.

18 (4) "Medicare" means the Health Insurance
19 for the Aged Act, Part 1 of Title I of the Social
20 Security Amendments of 1965, as amended (Public Law
21 89-97).

22 Revisor's Note

23 (1) Section 1(b)(1), V.T.I.C. Article 3.74,
24 refers to a "medicare supplement policy." The revised
25 law substitutes "benefit plan" for "policy" because
26 V.T.I.C. Article 3.74, revised as this chapter,
27 applies to evidences of coverage issued by health
28 maintenance organizations to supplement
29 reimbursements under Medicare. Health maintenance
30 organizations provide health benefit coverage, but the
31 organizations are not insurers, which issue policies.
32 Consequently, "benefit plan" is a more accurate term
33 than "policy." The substitution of "benefit plan" and
34 comparable changes necessary to ensure consistency in
35 terminology are made throughout this chapter.

36 (2) Section 1(b)(4), V.T.I.C. Article 3.74,
37 refers to the "Health Insurance for the Aged Act, Part
38 1 of Title I of the Social Security Amendments of 1965,

1 as amended (Public Law 89-97)." The correct citation
2 for that federal law is 42 U.S.C. Section 1395 et seq.,
3 and the revised law is drafted accordingly.

4 (3) The definition of "approved regulatory
5 program" is added to the revised law for drafting
6 convenience and to eliminate frequent, unnecessary
7 repetition of the substance of the definition.

8 Revised Law

9 Sec. 1652.002. MEDICARE SUPPLEMENT BENEFIT PLAN. (a)
10 "Medicare supplement benefit plan" means a group or individual
11 policy of accident and health insurance, a subscriber contract of a
12 group hospital service corporation operating under Chapter 842, or,
13 to the extent required by federal law, an evidence of coverage
14 issued by a health maintenance organization operating under Chapter
15 843 that is advertised, marketed, or designed primarily as a
16 supplement to reimbursements under Medicare for the hospital,
17 medical, or surgical expenses of an individual eligible for
18 Medicare.

19 (b) A policy, contract, subscriber contract, or evidence of
20 coverage is not considered to be a Medicare supplement benefit plan
21 if it is:

22 (1) a policy, contract, subscriber contract, or
23 evidence of coverage of one or more employers or labor
24 organizations, or of the trustees of a fund established by one or
25 more employers or labor organizations, or a combination, for
26 employees or former employees, or a combination, or for members or
27 former members, or a combination, of the labor organizations;

28 (2) a policy or health care benefit plan, including a
29 policy or contract of group insurance, a group contract of a group
30 hospital service corporation operating under Chapter 842, or a
31 group evidence of coverage issued by a health maintenance
32 organization operating under Chapter 843 that is not marketed or
33 held to be a Medicare supplement benefit plan; or

34 (3) an individual or group evidence of coverage issued

1 in accordance with a contract under Section 1833 or 1876, Social
2 Security Act (42 U.S.C. Section 1395l or 1395mm), by a health
3 maintenance organization operating under Chapter 843.

4 (c) The commissioner by rule may modify the definition of
5 "Medicare supplement benefit plan" provided by Subsection (a) to
6 the extent necessary for this state to qualify as a state with an
7 approved regulatory program. (V.T.I.C. Art. 3.74, Sec. 1(b)(3).)

8 Source Law

9 (3) "Medicare supplement policy" means a
10 group or individual policy of accident and sickness
11 insurance or a subscriber contract of a hospital
12 service corporation subject to Chapter 20 of this code
13 or, to the extent required by federal law, an evidence
14 of coverage issued by a health maintenance
15 organization subject to the Texas Health Maintenance
16 Organization Act, as amended (Chapter 20A, Vernon's
17 Texas Insurance Code), which policy, subscriber
18 contract, or such evidence of coverage is advertised,
19 marketed, or designed primarily as a supplement to
20 reimbursements under medicare for the hospital,
21 medical, or surgical expenses of persons eligible for
22 medicare; provided that the State Board of Insurance
23 may by rule modify the definition of medicare
24 supplement policy to the extent necessary for the
25 State of Texas to qualify as a state with an approved
26 regulatory program under the provisions of Public Law
27 96-265, Section 507(a), 94 Stat. 476 (42 U.S.C.A.
28 Section 1395ss (1980)). Such term does not include:

29 (A) a policy, contract, subscriber
30 contract, or evidence of coverage of one or more
31 employers or labor organizations, or of the trustees
32 of a fund established by one or more employers or labor
33 organizations, or combination thereof, for employees
34 or former employees, or combination thereof, or for
35 members or former members, or combination thereof, of
36 the labor organizations;

37 (B) a policy or health care benefit
38 plan including a policy or contract of group insurance
39 or group contract of a hospital service corporation
40 subject to Chapter 20 of this code or group evidence of
41 coverage issued by a health maintenance organization
42 subject to the Texas Health Maintenance Organization
43 Act (Chapter 20A, Vernon's Texas Insurance Code), when
44 such policy or plan is not marketed or held to be a
45 medicare supplement policy or benefit plan; or

46 (C) an individual or group evidence
47 of coverage issued pursuant to a contract under
48 Section 1876 or Section 1833 of the Federal Social
49 Security Act (42 U.S.C.A. Section 1395, et seq.) by a
50 health maintenance organization subject to the Texas
51 Health Maintenance Organization Act (Chapter 20A,
52 Vernon's Texas Insurance Code).

53 Revisor's Note

54 (1) Section 1(b)(3), V.T.I.C. Article 3.74,
55 refers to a policy of "accident and sickness

1 insurance." For consistency with modern usage, the
2 revised law substitutes "health" for "sickness."

3 (2) Section 1(b)(3), V.T.I.C. Article 3.74,
4 refers to a "hospital service corporation" subject to
5 V.T.I.C. Chapter 20, revised as Chapter 842 of this
6 code. The term most frequently used to refer to such a
7 corporation is "group hospital service corporation."
8 Consequently, the revised law substitutes "group
9 hospital service corporation" for "hospital service
10 corporation" for consistency of terminology in this
11 code.

12 (3) Section 1(b)(3), V.T.I.C. Article 3.74,
13 refers to "Section 1876 or Section 1833 of the Federal
14 Social Security Act (42 U.S.C.A. Section 1395, et
15 seq.)." The correct reference for those sections is
16 "Section 1833 or 1876, Social Security Act (42 U.S.C.
17 Section 1395l or 1395mm)," and the revised law is
18 drafted accordingly.

19 (4) Section 1(b)(3), V.T.I.C. Article 3.74,
20 refers to the State Board of Insurance. Chapter 685,
21 Acts of the 73rd Legislature, Regular Session, 1993,
22 abolished the board and transferred its functions to
23 the commissioner of insurance and the Texas Department
24 of Insurance. Throughout this chapter, references to
25 the board have been changed appropriately.

26 Revised Law

27 Sec. 1652.003. APPLICABILITY OF CHAPTER. This chapter
28 applies to an individual or group Medicare supplement benefit plan
29 delivered or issued for delivery in this state and, regardless of
30 the place where the plan was delivered or issued for delivery, a
31 certificate that was issued under a group Medicare supplement
32 benefit plan and delivered or issued for delivery in this state, if
33 the plan or certificate is issued by:

34 (1) a capital stock insurance company, including a

1 life, health and accident, and general casualty insurance company;
2 (2) a mutual life insurance company;
3 (3) a mutual assessment life insurance company,
4 including a statewide mutual assessment company, local mutual aid
5 association, and burial association;
6 (4) a mutual or mutual assessment association of any
7 kind, including an association subject to Section 887.102;
8 (5) a mutual insurance company other than a life
9 insurance company;
10 (6) a mutual or natural premium life or casualty
11 insurance company;
12 (7) a fraternal benefit society;
13 (8) a Lloyd's plan;
14 (9) a reciprocal or interinsurance exchange;
15 (10) a nonprofit hospital, medical, or dental service
16 corporation, including a corporation operating under Chapter 842;
17 (11) a stipulated premium company;
18 (12) another insurer that by law is required to be
19 authorized by the department; or
20 (13) a health maintenance organization operating
21 under Chapter 843, to the extent required by federal law. (V.T.I.C.
22 Art. 3.74, Secs. 1(a) (part), (b)(2).)

23 Source Law

24 Art. 3.74

25 Sec. 1. (a) Scope of Article. Notwithstanding
26 Section 2(b)(5) of Article 1.14-1 of this code, this
27 article applies to and governs group and individual
28 medicare supplement policies delivered or issued for
29 delivery in this state and certificates issued under
30 group medicare supplement policies that have been
31 delivered or issued for delivery in this state if those
32 policies or certificates are issued by capital stock
33 companies, including but not limited to life, health
34 and accident, and general casualty companies; mutual
35 life insurance companies; mutual assessment life
36 insurance companies, including but not limited to
37 statewide mutual assessment corporations, local
38 mutual aids, and burial associations; mutual and
39 mutual assessment associations of all kinds and types,
40 including but not limited to associations subject to
41 Article 14.17 of this code; mutual insurance companies
42 other than life; mutual or natural premium life or
43 casualty insurance companies; fraternal benefit
44 societies; Lloyds; reciprocal or inter-insurance

1 exchanges; nonprofit hospital, medical, or dental
2 service corporations, including but not limited to
3 companies subject to Chapter 20 of this code;
4 stipulated premium insurance companies; or any other
5 insurer which by law is required to be licensed by the
6 State Board of Insurance; and, to the extent required
7 by federal law, health maintenance organizations
8 subject to the Texas Health Maintenance Organization
9 Act (Chapter 20A, Vernon's Texas Insurance Code);
10 provided, that

11 [(b)]

12 (2) "Certificate" means, for the purposes
13 of this article, any certificate issued under a group
14 medicare supplement policy, which certificate has been
15 delivered or issued for delivery in this state
16 regardless of the place where the policy was delivered
17 or issued for delivery.

18 Revisor's Note

19 (1) Section 1(a), V.T.I.C. Article 3.74, states
20 that "[n]otwithstanding Section 2(b)(5) of Article
21 1.14-1 of this code, this article applies to and
22 governs" certain policies. The revised law omits the
23 reference to Section 2(b)(5), V.T.I.C. Article 1.14-1,
24 as unnecessary. Section 2(b)(5), revised as Section
25 101.053(b)(5) of this code, describes the types of
26 transactions that are not considered to be the
27 business of insurance and therefore are not regulated
28 under general Insurance Code provisions relating to
29 insurance regulation. Because V.T.I.C. Article 3.74,
30 revised as this chapter, provides explicit authority
31 to regulate Medicare supplement benefit plans,
32 including plans that otherwise would be described by
33 Section 101.053(b)(5), it is not necessary to negate
34 the effect of Section 2(b)(5), V.T.I.C. Article
35 1.14-1. The revised law omits "and governs" as
36 unnecessary because the language does not add to the
37 clear meaning of the law.

38 (2) Section 1(a), V.T.I.C. Article 3.74, refers
39 to companies and associations, "including but not
40 limited to" certain companies and associations. The
41 revised law omits "but not limited to" as unnecessary
42 because Section 311.005(13), Government Code (Code

1 Construction Act), and Section 312.011(19),
2 Government Code, provide that "includes" and
3 "including" are terms of enlargement and not of
4 limitation and do not create a presumption that
5 components not expressed are excluded.

6 (3) Section 1(a), V.T.I.C. Article 3.74, refers
7 to any other insurer required by law to be "licensed"
8 by the State Board of Insurance (now the Texas
9 Department of Insurance). The revised law substitutes
10 "authorized" for "licensed" for consistency of
11 terminology within this code.

12 Revised Law

13 Sec. 1652.004. CONSTRUCTION OF CHAPTER. (a) This chapter
14 may not be construed to enlarge the powers of an entity described by
15 Section 1652.003.

16 (b) This chapter controls to the extent of any conflict with
17 another provision of this code. (V.T.I.C. Art. 3.74, Secs. 1(a)
18 (part), 7 (part).)

19 Source Law

20 Sec. 1. (a) . . . this article shall not be
21 construed to enlarge the powers of any of the
22 enumerated companies.

23 Sec. 7. . . . in the event of any conflict
24 between the provisions of this article and any other
25 provisions of the Insurance Code, the provisions of
26 this article control to the extent of such conflict.

27 Revisor's Note

28 The revised law omits as unnecessary that part of
29 Section 7, V.T.I.C. Article 3.74, relating to the
30 cumulative effect of that article. An accepted
31 general principle of statutory construction requires a
32 statute to be given cumulative effect with other
33 statutes unless it provides otherwise or unless the
34 statutes are in conflict. The general principle
35 applies to this revision. The omitted law reads:

36 Sec. 7. The provisions of this
37 article are cumulative of all other law, but

1

2 Revised Law

3 Sec. 1652.005. RULES NECESSARY FOR CERTIFICATION. In
4 addition to other rules required or authorized by this chapter, the
5 commissioner shall adopt reasonable rules necessary and proper to
6 carry out this chapter, including rules adopted in accordance with
7 federal law relating to the regulation of Medicare supplement
8 benefit plan coverage that are necessary for this state to obtain or
9 retain certification as a state with an approved regulatory
10 program. (V.T.I.C. Art. 3.74, Sec. 10.)

11 Source Law

12 Sec. 10. In addition to other rules required or
13 authorized by this article, the State Board of
14 Insurance shall adopt rules in accordance with federal
15 law applicable to the regulation of medicare
16 supplement insurance coverage that are necessary for
17 the state to obtain or retain certification as a state
18 with an approved regulatory program under 42 U.S.C.
19 Section 1395ss and any other reasonable rules that are
20 necessary and proper to carry out this article.

21 [Sections 1652.006-1652.050 reserved for expansion]

22 SUBCHAPTER B. BENEFITS

23 Revised Law

24 Sec. 1652.051. MINIMUM STANDARDS. (a) The commissioner
25 shall adopt reasonable rules to establish specific standards for
26 provisions in Medicare supplement benefit plans and standards for
27 facilitating comparisons of different Medicare supplement benefit
28 plans. The standards are in addition to and must be in accordance
29 with:

30 (1) applicable laws of this state, including Chapters
31 842 and 1201;

32 (2) applicable federal law, rules, regulations, and
33 standards; and

34 (3) any model rules and regulations required by
35 federal law, including Section 1882, Social Security Act (42 U.S.C.
36 Section 1395ss).

37 (b) The standards may include provisions relating to:

38 (1) terms of renewability;

- (2) initial and subsequent conditions of eligibility;
- (3) nonduplication of coverage;
- (4) probationary periods;
- (5) benefit limitations, exceptions, and reductions;
- (6) elimination periods;
- (7) requirements for replacement;
- (8) recurrent conditions;
- (9) definitions of terms; and
- (10) exclusions required by state or federal law.

(c) The commissioner may adopt reasonable rules that specifically prohibit benefit plan provisions that:

(1) are not otherwise specifically authorized by statute; and

(2) the commissioner determines are unjust, unfair, or unfairly discriminatory to a person who is covered or proposed for coverage.

(d) Rules adopted under this section must include requirements that are at least equal to those required by federal law, rules, regulations, and standards, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Secs. 2(c), (d), (f).)

Source Law

(c) The State Board of Insurance shall issue reasonable rules to establish specific standards for provisions of medicare supplement policies and standards for facilitating comparison among the medicare supplement products of the insurer or entity offering such medicare supplement products. Such standards shall be in addition to and in accordance with applicable laws of this state, including but not limited to Subchapter G of Chapter 3, Chapter 20 of this Code, and applicable federal law, rules, regulations, and standards and any model rules and regulations required by 42 U.S.C. Section 1395ss and other federal law and may cover but shall not be limited to:

- (1) terms of renewability;
- (2) initial and subsequent conditions of eligibility;
- (3) nonduplication of coverage;
- (4) probationary periods;
- (5) benefit limitations, exceptions, and reductions;
- (6) elimination periods;
- (7) requirements for replacement;

1 (8) recurrent conditions;
2 (9) definitions of terms; and
3 (10) exclusions required by state or
4 federal law.

5 (d) The State Board of Insurance may issue
6 reasonable rules that specify prohibited provisions
7 not otherwise specifically authorized by statute
8 which, in the opinion of the State Board of Insurance,
9 are unjust, unfair, or unfairly discriminatory to any
10 person insured or proposed for coverage under a
11 medicare supplement policy.

12 (f) The rules issued by the State Board of
13 Insurance under this section must include requirements
14 that are at least equal to those required by federal
15 law, rules, regulations, and standards, including 42
16 U.S.C. Section 1395ss.

17 Revisor's Note

18 (1) Section 2(c), V.T.I.C. Article 3.74, refers
19 to laws, "including but not limited to" certain laws.
20 The revised law omits "but not limited to" for the
21 reason stated in Revisor's Note (2) to Section
22 1652.003.

23 (2) Section 2(c), V.T.I.C. Article 3.74, refers
24 to standards that "may cover but shall not be limited
25 to" certain terms. The revised law substitutes
26 "include" for "cover" because the terms are synonymous
27 in context and omits "but shall not be limited to" for
28 the reason stated in Revisor's Note (2) to Section
29 1652.003.

30 Revised Law

31 Sec. 1652.052. MINIMUM STANDARDS FOR BENEFITS AND CLAIM
32 PAYMENTS. (a) The commissioner shall adopt reasonable rules to
33 establish minimum standards for benefits and claim payments under
34 Medicare supplement benefit plans.

35 (b) The standards for benefits and claim payments must
36 include the requirements for certification of Medicare supplement
37 benefit plans prescribed by Section 1882, Social Security Act (42
38 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 3.)

39 Source Law

40 Sec. 3. (a) The State Board of Insurance shall
41 issue reasonable rules to establish minimum standards
42 for benefits and claim payments under medicare
43 supplement policies.

1 (b) Minimum standards for benefits and claim
2 payments shall include the requirements for
3 certification of medicare supplement policies as
4 provided by 42 U.S.C. Section 1395ss.

5 Revised Law

6 Sec. 1652.053. DUPLICATE BENEFITS PROHIBITED. A Medicare
7 supplement benefit plan or certificate in force in this state may
8 not contain benefits that duplicate benefits provided by Medicare.
9 (V.T.I.C. Art. 3.74, Sec. 2(a).)

10 Source Law

11 Sec. 2. (a) No medicare supplement insurance
12 policy or certificate in force in this state shall
13 contain benefits that duplicate benefits provided by
14 medicare.

15 Revised Law

16 Sec. 1652.054. BASIC PLAN. An entity described by Section
17 1652.003 that offers for sale in this state a Medicare supplement
18 benefit plan must offer a basic Medicare supplement benefit plan
19 that:

20 (1) provides only those benefits common to all
21 Medicare supplement benefit plans; and

22 (2) meets but does not exceed the minimum standards of
23 benefits for Medicare supplement benefit plans adopted by the
24 commissioner and authorized by Section 1882, Social Security Act
25 (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 2(b)
26 (part).)

27 Source Law

28 (b) Any insurer or other entity designated in
29 Section 1(a) of this article that offers for sale in
30 this state a medicare supplement insurance policy must
31 offer a basic medicare supplement policy that provides
32 only those benefits common to all medicare supplement
33 policies, and that meets, but does not exceed the
34 minimum standards of benefits for medicare supplement
35 policies authorized by 42 U.S.C. Section 1395ss and
36 adopted by the board. . . .

37 Revisor's Note

38 Section 2(b), V.T.I.C. Article 3.74, refers to an
39 "insurer or other entity" designated under Section
40 1(a) of that article. The revised law substitutes
41 "entity" for "insurer or other entity" because the

1 terms are synonymous in context. Similar changes are
2 made throughout this chapter.

3 Revised Law

4 Sec. 1652.055. ADDITIONAL BENEFITS. (a) In addition to
5 the basic Medicare supplement benefit plan described by Section
6 1652.054, an entity may offer additional Medicare supplement
7 benefit plans for sale in this state.

8 (b) The combination of benefits provided by an additional
9 plan must conform to one of the benefit packages adopted by the
10 commissioner and authorized by Section 1882, Social Security Act
11 (42 U.S.C. Section 1395ss).

12 (c) The commissioner by rule shall provide for the approval
13 of new or innovative benefits that may be provided in a plan other
14 than the basic plan and that otherwise comply with this subchapter.
15 The benefits must:

16 (1) be offered in a manner consistent with the goal of
17 Medicare supplement benefit plan simplification; and

18 (2) meet the requirements prescribed by Section 1882,
19 Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art.
20 3.74, Sec. 2(b) (part).)

21 Source Law

22 (b) . . . In addition to this basic medicare
23 supplement insurance policy, any such insurer or other
24 entity may offer for sale in this state additional
25 medicare supplement policies. The combination of
26 benefits provided by the additional policies must
27 conform to one of the benefit packages authorized by 42
28 U.S.C. Section 1395ss and adopted by the board. The
29 board by rule shall provide for the approval of new or
30 innovative benefits that may be provided in a policy
31 other than the basic policy and that otherwise comply
32 with this section. The new or innovative benefits
33 shall be offered in a manner consistent with the goal
34 of medicare supplement policy simplification and shall
35 meet the requirements set forth in 42 U.S.C. Section
36 1395ss.

37 Revised Law

38 Sec. 1652.056. COVERAGE FOR MAMMOGRAPHY. (a) In this
39 section, "low-dose mammography" means the x-ray examination of the
40 breast using equipment dedicated specifically for mammography,
41 including the x-ray tube, filter, compression device, screens,

1 films, and cassettes, with an average radiation exposure delivery
2 of less than one rad mid-breast, with two views for each breast.

3 (b) Each Medicare supplement benefit plan must include
4 coverage for an annual screening by low-dose mammography for the
5 presence of occult breast cancer.

6 (c) The coverage for the annual screening may not be less
7 favorable than coverage for other radiological examinations and
8 must be subject to the same dollar limits, deductibles, and
9 coinsurance factors. (V.T.I.C. Art. 3.74, Sec. 3A.)

10 Source Law

11 Sec. 3A. (a) In this section, "low-dose
12 mammography" means the X-ray examination of the breast
13 using equipment dedicated specifically for
14 mammography, including the X-ray tube, filter,
15 compression device, screens, films, and cassettes,
16 with an average radiation exposure delivery of less
17 than one rad mid-breast, with two views for each
18 breast.

19 (b) Each Medicare supplement policy delivered,
20 issued for delivery, or renewed in this state must
21 include coverage for an annual screening by low-dose
22 mammography for the presence of occult breast cancer
23 within the provisions of the policy that is not less
24 favorable than for other radiological examinations and
25 subject to the same dollar limits, deductibles, and
26 co-insurance factors.

27 Revised Law

28 Sec. 1652.057. WAIVER OF WAITING PERIOD. (a) An entity
29 that delivers or issues for delivery in this state a Medicare
30 supplement benefit plan or certificate that replaces a Medicare
31 supplement benefit plan or certificate shall give credit for the
32 satisfaction or partial satisfaction of any waiting period,
33 elimination period, or probationary period for a preexisting
34 condition that has been satisfied under the plan being replaced.

35 (b) A replacement plan that clearly provides a new or
36 additional benefit may include appropriate and clearly stated
37 periods as a condition for payment of the new or additional benefit.
38 (V.T.I.C. Art. 3.74, Sec. 8.)

39 Source Law

40 Sec. 8. An insurer or other entity that delivers
41 or issues for delivery a medicare supplement policy or
42 certificate in this state that replaces an existing
43 medicare supplement policy or certificate shall give

1 credit for the satisfaction or partial satisfaction of
2 any waiting periods, elimination periods, and
3 probationary periods that are applicable to
4 preexisting conditions and that have already been
5 satisfied under the policy being replaced. Any new or
6 additional benefits that are clearly set forth in the
7 replacement policy may include appropriate clearly
8 stated time periods as a condition of payment for such
9 new or additional benefits.

10 Revised Law

11 Sec. 1652.058. COVERAGE FOR PREEXISTING CONDITION. (a) A
12 Medicare supplement benefit plan may not contain a provision that
13 excludes coverage for a claim for losses incurred more than six
14 months after the effective date of coverage for a preexisting
15 condition.

16 (b) A Medicare supplement benefit plan may not define a
17 preexisting condition more restrictively than a condition for which
18 medical advice was given or treatment was recommended by or
19 received from a physician within six months before the effective
20 date of coverage. (V.T.I.C. Art. 3.74, Sec. 2(e).)

21 Source Law

22 (e) Notwithstanding any other provisions of the
23 law, a medicare supplement policy may not deny a claim
24 for losses incurred more than six months from the
25 effective date of coverage for a preexisting
26 condition. Such policy may not define a preexisting
27 condition more restrictively than a condition for
28 which medical advice was given or treatment was
29 recommended by or received from a physician within six
30 months before the effective date of coverage.

31 [Sections 1652.059-1652.100 reserved for expansion]

32 SUBCHAPTER C. LOSS RATIO STANDARDS

33 Revised Law

34 Sec. 1652.101. LOSS RATIO STANDARDS. (a) A Medicare
35 supplement benefit plan must return to a plan holder benefits that
36 are reasonable in relation to the premium charged.

37 (b) The commissioner shall adopt reasonable rules to
38 establish minimum loss ratio standards for Medicare supplement
39 benefit plans. The standards must be established:

40 (1) on the basis of incurred claims experience and
41 earned premiums for the entire period for which rates are computed
42 to provide coverage;

1 (2) in accordance with accepted actuarial principles
2 and practices; and

3 (3) to the extent necessary for the state to obtain or
4 retain certification as a state with an approved regulatory
5 program. (V.T.I.C. Art. 3.74, Secs. 4(a), (d).)

6 Source Law

7 Sec. 4. (a) Medicare supplement policies shall
8 return to holders of a medicare supplement policy
9 benefits which are reasonable in relation to the
10 premium charged. The State Board of Insurance shall
11 issue reasonable rules to establish minimum standards
12 for loss ratios of medicare supplement policies on the
13 basis of incurred claims experience and earned
14 premiums for the entire period for which rates are
15 computed to provide coverage and in accordance with
16 accepted actuarial principles and practices.

17 (d) The State Board of Insurance shall issue
18 reasonable rules providing loss ratio standards
19 applicable to rates charged for medicare supplement
20 policies to the extent necessary for the state to
21 obtain or retain certification as a state with an
22 approved regulatory program under 42 U.S.C. Section
23 1395ss.

24 Revised Law

25 Sec. 1652.102. FILING REQUIREMENTS. (a) Annually, each
26 entity providing Medicare supplement benefit plans in this state
27 shall file with the department the entity's rates, rating schedule,
28 and supporting documentation demonstrating that:

29 (1) the entity is complying with the applicable loss
30 ratio standards of this state; and

31 (2) the actual and expected losses in relation to
32 premiums comply with the requirements of this subchapter and the
33 rules adopted by the commissioner.

34 (b) The documentation required by Subsection (a) must
35 include a report of the ratio of incurred losses to covered premiums
36 for the preceding calendar year, illustrated by calendar year of
37 issue.

38 (c) The commissioner may adopt rules relating to filing
39 requirements for rates, rating schedules, and loss ratios.
40 (V.T.I.C. Art. 3.74, Secs. 4(b), (c).)

1 duplications with Medicare.

2 (b) A rider, endorsement, or plan form required by
3 Subsection (a) must provide a clear description of the Medicare
4 supplement benefits provided by the plan. (V.T.I.C. Art. 3.74,
5 Sec. 4(e).)

6 Source Law

7 (e) Before the effective date of any medicare
8 benefit changes required by federal law as applicable
9 to existing policies, every insurer, health care
10 service plan, or other entity providing medicare
11 supplement insurance or contracts in this state shall
12 file with the commissioner, in accordance with Article
13 3.42 of this code:

14 (1) appropriate premium adjustments
15 necessary to produce loss ratios as originally
16 anticipated for the applicable policies or contracts,
17 and such supporting documents as necessary to justify
18 the adjustment shall accompany the filing; and

19 (2) appropriate riders, endorsements, or
20 policy forms needed to accomplish the medicare
21 supplement insurance modifications necessary to
22 eliminate benefit duplications with medicare.

23 Those riders, endorsements, or policy forms shall
24 provide a clear description of the medicare supplement
25 benefits provided by the policy or contract.

26 Revised Law

27 Sec. 1652.105. REPORTING LOSS RATIO INFORMATION TO
28 SECRETARY OF HEALTH AND HUMAN SERVICES. To the extent necessary
29 for this state to obtain or retain certification as a state with an
30 approved regulatory program, the department shall comply with
31 federal requirements relating to periodic reporting of loss ratio
32 information to the secretary of health and human services, based on
33 a uniform methodology, as authorized by federal law. (V.T.I.C.
34 Art. 3.74, Sec. 4(g).)

35 Source Law

36 (g) The board shall comply with federal
37 requirements relating to periodical reporting on loss
38 ratio information to the Secretary of Health and Human
39 Services, based on uniform methodology for reporting
40 loss ratios, as authorized by federal law to the extent
41 necessary for this state to obtain or retain
42 certification as a state with an approved regulatory
43 program under 42 U.S.C. Section 1395ss.

1 [Sections 1652.106-1652.150 reserved for expansion]

2 SUBCHAPTER D. CONSUMER INFORMATION AND NOTICE

3 Revised Law

4 Sec. 1652.151. RULES RELATING TO DISCLOSURE. The rules
5 adopted under Sections 1652.152, 1652.153, and 1652.154 must
6 include provisions and requirements that are at least equal to
7 those required by federal law, including the rules, regulations,
8 and standards adopted under Section 1882, Social Security Act (42
9 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Secs. 5(b) (part),
10 (f).)

11 Source Law

12 (b) . . . The rules adopted by the board
13 governing the outline of coverage must include
14 provisions at least equal to those required by rules,
15 regulations, and standards adopted under 42 U.S.C.
16 Section 1395ss or required by other federal law.

17 (f) Any rules adopted by the board under this
18 section must include requirements that are at least
19 equal to those required by rules, regulations, and
20 standards adopted under 42 U.S.C. Section 1395ss or
21 required by other federal law.

22 Revised Law

23 Sec. 1652.152. OUTLINE OF COVERAGE. (a) To provide for
24 full and fair disclosure in the sale of Medicare supplement benefit
25 plans, a Medicare supplement benefit plan or certificate may not be
26 delivered or issued for delivery in this state unless an outline of
27 coverage that complies with this section is delivered to the
28 applicant when the applicant applies for the coverage.

29 (b) The commissioner by rule shall prescribe the format and
30 content of the outline of coverage required by Subsection (a). The
31 rules must address the style, arrangement, and overall appearance
32 of the outline of coverage, including the size, color, and
33 prominence of type and the arrangement of text and captions.
34 (V.T.I.C. Art. 3.74, Secs. 5(a), (b) (part).)

35 Source Law

36 Sec. 5. (a) In order to provide for full and
37 fair disclosure in the sale of medicare supplement
38 policies, no medicare supplement policy or certificate
39 shall be delivered or issued for delivery in this state
40 unless an outline of coverage complying with the

1 requirements of this section is delivered to the
2 applicant at the time application is made.

3 (b) The State Board of Insurance by rule shall
4 prescribe the format and content of the outline of
5 coverage required by Subsection (a) of this section.
6 For purposes of this section, "format" means style,
7 arrangements, and overall appearance, including such
8 items as the size, color, and prominence of type and
9 the arrangement of text and captions. . . .

10 Revised Law

11 Sec. 1652.153. INFORMATIONAL BROCHURE. (a) The
12 commissioner by rule may prescribe a standard form and the contents
13 of an informational brochure intended to improve the ability of an
14 individual eligible for Medicare to understand Medicare and to
15 select the most appropriate Medicare supplement coverage.

16 (b) Except as provided by Subsection (c), the commissioner
17 by rule may require that the informational brochure be provided to
18 an individual eligible for Medicare concurrently with delivery of
19 the outline of coverage.

20 (c) If the plan is a direct response Medicare supplement
21 benefit plan, the commissioner by rule may require that the
22 informational brochure be provided on request to an individual
23 eligible for Medicare at any time not later than the time the plan
24 is delivered. (V.T.I.C. Art. 3.74, Sec. 5(c).)

25 Source Law

26 (c) The State Board of Insurance may prescribe
27 by rule a standard form and the contents of an
28 informational brochure for persons eligible for
29 medicare which is intended to improve the buyer's
30 ability to select the most appropriate coverage and
31 improve the buyer's understanding of medicare. Except
32 in the case of direct response medicare supplement
33 policies, the State Board of Insurance may require by
34 rule that the informational brochure be provided to
35 any prospective insureds eligible for medicare
36 concurrently with delivery of the outline of coverage.
37 With respect to direct response medicare supplement
38 policies, the State Board of Insurance may require by
39 rule that the prescribed brochure be provided upon
40 request to any prospective insureds eligible for
41 medicare but in no event later than the time of policy
42 delivery.

43 Revisor's Note

44 Section 5(c), V.T.I.C. Article 3.74, refers to
45 "prospective insureds eligible for medicare." The
46 revised law omits "prospective insureds" as redundant

1 because an individual eligible for Medicare is also a
2 "prospective insured."

3 Revised Law

4 Sec. 1652.154. NOTICE RELATING TO OTHER TYPES OF
5 COVERAGE. (a) The commissioner may adopt reasonable rules for
6 captions or notice requirements for each accident and health
7 insurance policy, subscriber contract, or evidence of coverage sold
8 to an individual eligible for Medicare that are determined to be in
9 the public interest and designed to inform the individual that a
10 particular coverage is not a Medicare supplement benefit plan.
11 This subsection does not apply to:

- 12 (1) a Medicare supplement benefit plan;
13 (2) a disability income policy;
14 (3) a basic, catastrophic, or major medical expense
15 policy;
16 (4) a single premium nonrenewable policy; or
17 (5) another policy, contract, or subscriber contract
18 described by Section 1652.002(b)(1) or (2).

19 (b) The commissioner may adopt reasonable rules to govern
20 the full and fair disclosure of information relating to replacing
21 an accident and health insurance policy, a subscriber contract, or
22 a certificate by an individual eligible for Medicare. (V.T.I.C.
23 Art. 3.74, Secs. 5(d), (e).)

24 Source Law

25 (d) The State Board of Insurance may promulgate
26 reasonable rules for captions or notice requirements
27 determined to be in the public interest and designed to
28 inform prospective insureds, subscribers, or
29 enrollees that particular coverages are not medicare
30 supplement coverages for all accident and sickness
31 insurance policies or subscriber contracts or
32 evidences of coverage sold to persons eligible for
33 medicare, other than:

- 34 (1) medicare supplement policies;
35 (2) disability income policies;
36 (3) basic, catastrophic, or major medical
37 expense policies;
38 (4) single premium nonrenewable policies;
39 or
40 (5) other policies, contracts, or
41 subscriber contracts as specified in Paragraphs (A)
42 and (B) of Subsection (b) of Section 1 of this article.
43 (e) The State Board of Insurance may further

1 promulgate reasonable rules to govern the full and
2 fair disclosure of the information in connection with
3 the replacement of accident and sickness policies,
4 subscriber contracts, or certificates by persons
5 eligible for medicare.

6 Revisor's Note

7 (1) Section 5(d), V.T.I.C. Article 3.74, refers
8 to "prospective insureds, subscribers, or enrollees."
9 The revised law substitutes "individual eligible for
10 Medicare" for consistency of terminology in this
11 chapter. An individual eligible for Medicare is also a
12 "prospective insured, subscriber, or enrollee."

13 (2) Sections 5(d) and (e), V.T.I.C. Article
14 3.74, refer to "accident and sickness" insurance
15 policies. The revised law substitutes "health" for
16 "sickness" for the reason stated in Revisor's Note (1)
17 to Section 1652.002.

18 (3) Section 5(d)(5), V.T.I.C. Article 3.74,
19 refers to policies, contracts, or subscriber contracts
20 as specified in "Paragraphs (A) and (B) of Subsection
21 (b) of Section 1 of this article." It is apparent from
22 the context of the source law that the correct
23 cross-reference is Sections 1(b)(3)(A) and (B),
24 revised as Sections 1652.002(b)(1) and (2), and the
25 revised law is drafted accordingly.

26 Revised Law

27 Sec. 1652.155. RIGHT TO RETURN FOR REFUND; NOTICE. (a) If
28 an applicant is not satisfied for any reason after examining a
29 Medicare supplement benefit plan document or certificate, the
30 applicant is entitled to receive a refund of the premium if the
31 applicant returns the document or certificate not later than the
32 30th day after the date it is delivered.

33 (b) The entity issuing the plan or certificate shall refund
34 the premium directly to the applicant in a timely manner.

35 (c) A Medicare supplement benefit plan or certificate must
36 have a notice stating the substance prescribed by Subsection (a)

1 prominently printed on the first page of or attached to the plan or
2 certificate. (V.T.I.C. Art. 3.74, Sec. 6.)

3 Source Law

4 Sec. 6. Medicare supplement policies or
5 certificates shall have a notice prominently printed
6 on the first page of such policy or certificate or
7 attached thereto stating in substance that the
8 applicant shall have the right to return such policy or
9 certificate within 30 days of its delivery and to have
10 the premium refunded if, after examination of such
11 policy or certificate, the applicant is not satisfied
12 for any reason. A refund made pursuant to this section
13 must be paid directly to the applicant in a timely
14 manner by the entity issuing the policy or
15 certificate.

16 Revised Law

17 Sec. 1652.156. ADVERTISING FILING REQUIREMENTS. (a) The
18 commissioner shall adopt reasonable rules to require each entity
19 described by Section 1652.003 to file with the department a copy of
20 any advertisement relating to Medicare supplement benefit plans
21 that the entity intends to use in this state. The rules must
22 require that the entity file the copy not later than the 60th day
23 before the date of intended use.

24 (b) At the expiration of the 60-day period provided by
25 Subsection (a), an advertisement filed in accordance with that
26 subsection is considered acceptable, unless before the end of that
27 60-day period the department notifies the entity of the
28 advertisement's nonacceptance.

29 (c) An entity may not use an advertisement for Medicare
30 supplement benefit plans that does not comply with state law,
31 including department rules. (V.T.I.C. Art. 3.74, Sec. 9.)

32 Source Law

33 Sec. 9. (a) The State Board of Insurance shall
34 issue reasonable rules to require each entity
35 designated in Section 1(a) of this article that
36 delivers or issues for delivery in this state a group
37 or individual medicare supplement policy or
38 certificate to file with the State Board of Insurance,
39 not later than the 60th day before the date of the
40 intended use of the advertisement, a copy of the
41 advertisement that is intended for use in this state
42 and that relates to medicare supplement insurance.
43 The advertisement must comply with applicable law of
44 this state and rules of the State Board of Insurance.

45 (b) At the expiration of the 60-day period
46 provided by Subsection (a) of this section, any

1 advertisement that is filed under that subsection
2 shall be deemed acceptable, unless before the end of
3 that 60-day period the board has notified the entity of
4 its nonacceptance.

5 (c) An entity may not use an advertisement for
6 medicare supplement insurance that does not comply
7 with this state's law and the board's rules.

8 Revisor's Note

9 Section 9(a), V.T.I.C. Article 3.74, refers to an
10 "entity designated in Section 1(a) of this article
11 that delivers or issues for delivery in this state a
12 group or individual medicare supplement policy or
13 certificate." The revised law omits the reference to
14 "delivers or issues for delivery in this state a group
15 or individual medicare supplement policy or
16 certificate" because an entity "designated" by Section
17 1(a), V.T.I.C. Article 3.74, revised as Section
18 1652.003, is by the terms of Section 1(a) such an
19 entity.

20 [Sections 1652.157-1652.200 reserved for expansion]

21 SUBCHAPTER E. AGENTS

22 Revised Law

23 Sec. 1652.201. INFORMATION PROVIDED TO AGENTS. (a) An
24 entity that offers a Medicare supplement benefit plan for sale in
25 this state shall provide to each agent authorized to sell that plan
26 information relating to:

- 27 (1) Medicare;
28 (2) the Medicare supplement benefit plans offered by
29 that entity; and
30 (3) the agent's ethical obligations to clients.

31 (b) The commissioner by rule may prescribe the information
32 that must be provided under this section. (V.T.I.C. Art. 3.74, Sec.
33 9A.)

34 Source Law

35 Sec. 9A. (a) Any insurer or other entity that
36 offers for sale in this state a medicare supplement
37 policy shall provide to each agent authorized to sell
38 its medicare supplement policies information related
39 to medicare, the medicare supplement policies offered
40 by the insurer or other entity, and the agent's ethical

obligations to clients.
(b) The State Board of Insurance may prescribe by rule the information that must be provided under this section.

Revised Law

Sec. 1652.202. PERMITTED COMPENSATION ARRANGEMENTS. (a) The commissioner by rule shall limit the commission or other compensation that may be paid to an agent for the sale of a Medicare supplement benefit plan or certificate, including a replacement plan or certificate.

(b) The rules must conform to, but may not be more restrictive than, the requirements of federal law necessary for this state to obtain or retain certification as a state with an approved regulatory program. (V.T.I.C. Art. 3.74, Sec. 9B.)

Source Law

Sec. 9B. The board shall adopt rules limiting the commission or other compensation that may be paid to an agent for the sale of a medicare supplement policy or certificate, including replacement policies or certificates. Rules adopted by the board under this section must conform to, but may not be more restrictive than, the requirements of federal law that must be met for the state to obtain or retain certification as a state with an approved regulatory program under 42 U.S.C. Section 1395ss.

TITLE 9. PROVISIONS APPLICABLE TO LIFE AND HEALTH COVERAGES

CHAPTER 1701. POLICY FORMS

TITLE 9. PROVISIONS APPLICABLE TO LIFE AND HEALTH COVERAGES

CHAPTER 1701. POLICY FORMS

SUBCHAPTER A. GENERAL PROVISIONS

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[Sections 1701.006-1701.050 reserved for expansion]

SUBCHAPTER B. FILING REQUIREMENT

Sec. 1701.051. FILING REQUIRED 1390